

FOR STATE
HEALTH DEPT.

EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FMJ. Page 5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. CDUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived, if institution: Reside before admission) a. STATE ENGLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. LENGTH OF STAY IN 1b LESS 1 HR	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTON HUNTS ENGLAND	
3. NAME OF DECEASED (Type or print) First SHARON Middle K. Last AGEE		f. STREET ADDRESS HILL FARM	
4. DATE OF DEATH Month MAY Day 19 Year 1967		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 FEB 1963
9. AGE (In years last birthday) 4 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE CHILD		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) NELLIS AFB, NEVADA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WENDELL W. AGEE		14. MOTHER'S MAIDEN NAME JUNE A. EVANS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT WENDELL W. AGEE		Address ROUTE #1 PIKEVILLE, TENN.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SECOND AND THIRD DEGREE BURNS 450% OF BODY 9160 DUE TO (b) RENAL FAILURE DUE TO (c) HYPERPYREXIA		INTERVAL BETWEEN ONSET AND DEATH 11 HRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) BURNED CLOTHING IN HOME	
20c. TIME OF INJURY Month, Day, Year Hour 8:30 p.m. 19 MAY 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME		20f. (City or town) (County) (State) ALCONBURY, HUNTS ENGLAND	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE DAYTON O WATKINS		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 5-22-67	
EXAMINER'S NAME (Type) DAYTON O WATKINS		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 5318 annapolis rd Address (Street, city, town, or county) Blodensburg Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 25 MAY 1967	
23c. NAME OF CEMETERY OR CREMATORY IRON HILL CEMETERY		23d. LOCATION (City, town or county) (State) PIKEVILLE, TENNESSEE	
24. FUNERAL DIRECTOR W.W. CHAMBERS, GO		ADDRESS RIVERDALE, MD	
25a. REC'D BY REGISTRAR MAY 25 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, within any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
07031 Item #2c & d Film #0359 6/12/67											
07014											
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN ID 5 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lanham d. STREET ADDRESS 7151 Hawthorne St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Frederick			First			Middle			Last		
5. SEX Male			6. COLOR OR RACE White			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 2/17/84		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Baker			11. BIRTHPLACE (County & State, or foreign country) New York			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. 578-09-6727			17. INFORMANT Jean Allison			Address 2843 Minn Ave S.E. Washington, D.C.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) uremia 6000 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) pyelonephritis chronic DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 6 weeks 6 months											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (MRS. ROSEMARY) attended the deceased from 1966 , 19, to May 31 , 1967, that (I) was last saw the deceased alive on May 31 , 1967, and that death occurred at 4:55 PM , from the causes and on the date stated above.											
22a. SIGNATURE Leon Levitsky						22b. DATE SIGNED May 31, 1967					
22c. PHYSICIAN'S NAME (Type) Leon Levitsky, M. D.						22d. ADDRESS 3408 Rhode Island Ave. Mt. Rainier, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 6-3-1967			23c. NAME OF CEMETERY OR CREMATORY Mt Olivet			23d. LOCATION (City, town or county) (State) Wash, D.C.		
24. FUNERAL DIRECTOR Matthew 131-1124 St. S.E. D.C.						25a. REC'D BY REGISTRAR JUN 2 1967			25b. REGISTRAR'S SIGNATURE Charles Judge		

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Prince George

George

Prince George District Hospital

Technical

Medical

Male

Age

21/1/84

83

Physiotherapy Clinic

rehabilitation

1984

[Signature]

John Davidson M.D.

John Davidson M.D. (Physician)

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if only delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-30, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

07032

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07015

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 7301 Forest Road			
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Antonetz				4. DATE OF DEATH Month 5 Day 18 Year 19 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 Feb. 1967		9. AGE (In years last birthday) yrs. 3	IF UNDER 1 YEAR Months 3 Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Takoma Park, Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME UNK				14. MOTHER'S MAIDEN NAME Cassandra Jo Antonetz			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. N/A		17. INFORMANT P.G. WELSHARE Address Brentwood, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Bilateral bronchopneumonia DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 5-19-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF May 24, 1967		23c. NAME OF CEMETERY OR CREMATORY Carver Memorial Cemetery		23d. LOCATION (City or Town) (County) (State) Laurel, Maryland	
24. FUNERAL DIRECTOR Harold S. Wade, Laurel, Maryland				25a. REC'D BY REGISTRAR MAY 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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VR A15ME (51)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07033

07016

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover 16.1	
c. LENGTH OF STAY IN 1b DOA		d. STREET ADDRESS 7404 B Landover Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dvira Middle Arkinzadeh Last Arkinzadeh		4. DATE OF DEATH Month 5 Day 4 Year 1967	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 Feb. 1908
9. AGE (In years lost birthday) 59 yrs.		10. IF UNDER 1 YEAR Months 5 Days 4 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? Iran	
13. FATHER'S NAME Moshe Kaplan		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Son Abraham H. Arkinzadeh		Address 7404B Landover Rd., Landover, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 974X DUE TO Hangang Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hung self with rope from hook on door.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 8:30am p.m. 5-4- 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/> 7404 Landover Rd., Hyattsville, Md.	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 5-4-67		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-10-67	23c. NAME OF CEMETERY OR CREMATORY Jewish Cemetery	23d. LOCATION (City or Town) (County) (State) Tel Aviv, Israel
24. FUNERAL DIRECTOR Bernard Danzansky & Sons St., NW, Wash. DC		25a. REC'D BY REGISTRAR MAY 5 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



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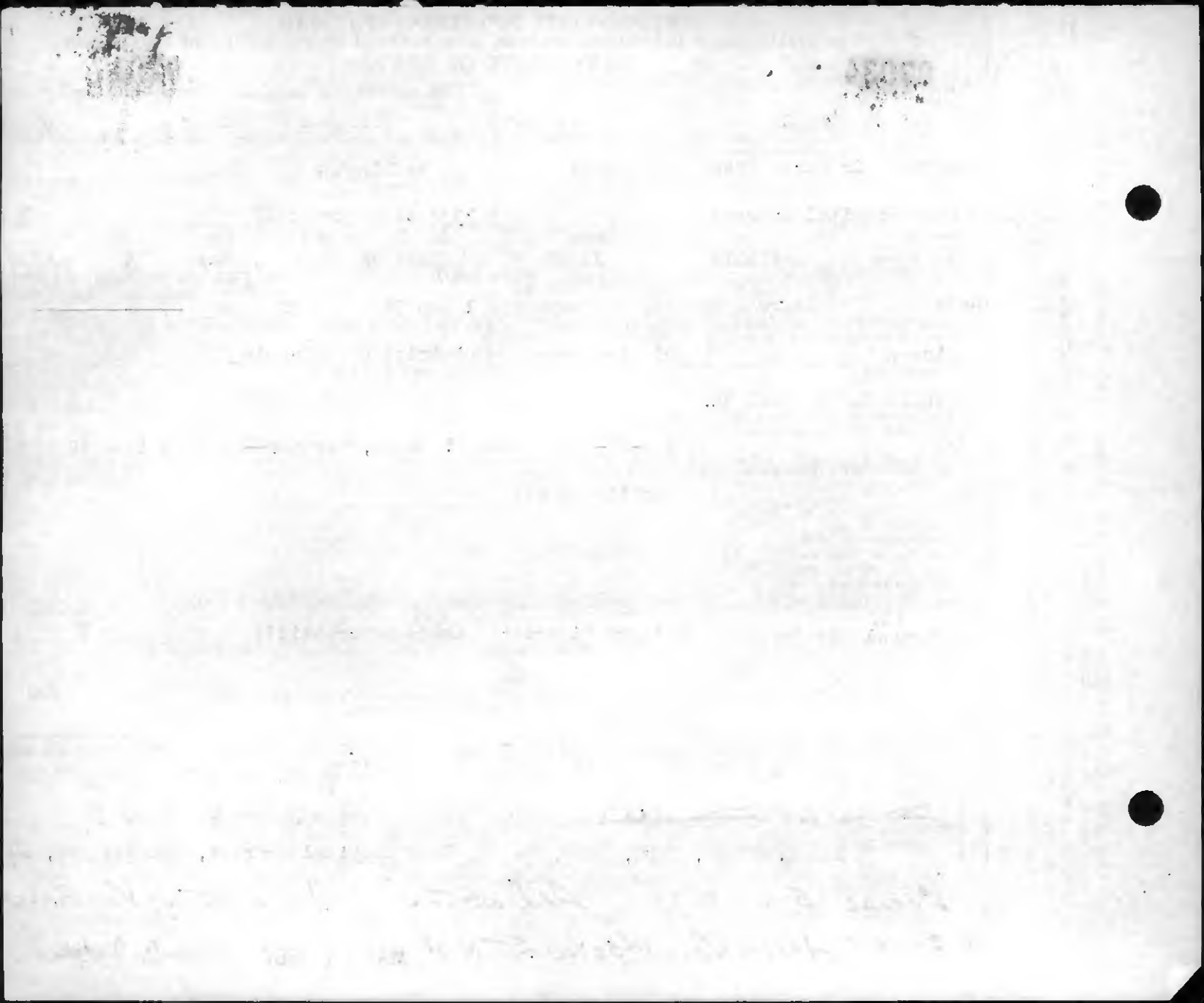
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
07034					07017						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
a. COUNTY PRINCE GEORGES					a. STATE MARYLAND						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews Air Force Base					b. COUNTY DISTRICT OF COLUMBIA						
c. LENGTH OF STAY IN 1b 2 days					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF Hospital Andrews					d. STREET ADDRESS 3332 11th Street NE						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. SEX			6. COLOR OR RACE		
First WILLIE			Middle JAMES			Last BANKS JR			Date May 5 19 67		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			8. DATE OF BIRTH 1 Sep 34			9. AGE (In years last birthday) 32 yrs.			IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Airman			10b. KIND OF BUSINESS OR INDUSTRY US Air Force			11. BIRTHPLACE (County & State, or foreign country) District of Columbia			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME WILLIE JAMES BANKS SR.						14. MOTHER'S MAIDEN NAME EDNA HENRIETTA BOND					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. 579-48-6234			17. INFORMANT EDNA H. BANKS, Mother---Same as item #2			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4330 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Alcohol withdrawal (1) Seizure disorder (2) Acute pancreatitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NA 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 3 May , 19 67 , to 5 May , 19 67 , that (I) (we) last saw the deceased alive on 5 May 67 19 67 , and that death occurred at 1138 PM from the causes and on the date stated above. 22a. SIGNATURE Ira A. Gould M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 6 May 67 22c. PHYSICIAN'S NAME (Type) IRA A. GOULD, CAPT, USAF, MC 22d. ADDRESS USAF Hospital Andrews, Andrews AFB, DC 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 5-10-1967 23c. NAME OF CEMETERY OR CREMATORY ARLINGTON 23d. LOCATION (City, town or county) (State) ARLINGTON VIRGINIA 24. FUNERAL DIRECTOR W. ERNEST JARVIS Co. 25a. REC'D BY REGISTRAR 1432 New St. N.W. 25b. REGISTRAR'S SIGNATURE Charles Judge MAY 11 1967											



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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Prince Georges		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN b 14 hours		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE Maryland		b. COUNTY Prince Georges		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital						d. STREET ADDRESS 7020 St. Annes Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Mary Elizabeth Barber						4. DATE OF DEATH Month Day Year May 18, 1967					
5 SEX Female		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Oct. 7, 1894		9 AGE (In years last birthday) 72 yrs		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Housewife	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11 BIRTHPLACE (County & State, or foreign country) Washington Co., Md.				12 COUNTRY OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Daniel Oscar Reynolds						14. MOTHER'S MAIDEN NAME Mary Catherine Albin					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO 214 09 1656A		17. INFORMANT Address Lois J. Brooke Same as #2 (granddaughter)					
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Coronary occlusion left DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) this hospital attended the deceased from April 17, 1967 , to May 18, 1967 , that () we last saw the deceased alive on May 18, 1967 , and that death occurred at 2:08 AM , from causes and on the date stated above.											
22a. SIGNATURE Garry Rosenberg						MD ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 5/18/67			
22c. PHYSICIAN'S NAME (Type) Garry Rosenberg						22d. ADDRESS 6501 Landover Rd. Cheverly, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/20/67		23c. NAME OF CEMETERY OR CREMATORY Rest Haven				23d. LOCATION (City or Town) (County) (State) Hagerstown Md.			
24. FUNERAL DIRECTOR Rest Haven Funeral Chapel						ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE MAY 22 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07036

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07019

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly		c LENGTH OF STAY N 1b DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d STREET ADDRESS 3715 Kennedy Pl.	
3 NAME OF DECEASED (Type or print) First Norris Middle A Last Barron		4 DATE OF DEATH Month 5 Day 3 Year 19 67	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 4-14-1910
9 AGE (In years lost birthday) 57 yrs		10 UNDER 24 HRS Months 3 Days 19 Hours 67 Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Upholsterer		10b KIND OF BUSINESS OR INDUSTRY Self Employed	
11 BIRTHPLACE (State or foreign country) Washington, D.C.		12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME Leonard G. Barron		14 MOTHER'S MAIDEN NAME Alice Norris	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 678 12 3057	
17 INFORMANT Margaret E. Whitmore, (same as Item 2)		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH minutes over 4 yrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item B)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 5-4-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city town or county)	
23a BURIAL CREMATION REMOVAL (Specify) Burial	23b DATE THEREOF May 16, 1967	23c NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem	23d LOCATION (City or town) (County) (State) Montgomery County, Md.
24 FUNERAL DIRECTOR'S NAME (Type) H. Don. DeVol		ADDRESS D.C. 2222 Wis. Ave. N.W. Wash.	
25a REC'D BY REGISTRAR MAY 11 1967		25b REGISTRAR'S SIGNATURE Charles Judge	

10/15

10/15



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. **THIS** may be returned for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07040

07023

1 PLACE OF DEATH a COUNTY <u>Prince George's</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a STATE <u>Virginia</u> b. COUNTY			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Cheverly</u>		c LENGTH OF STAY IN 1b <u>DOA</u>		c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Alexandria</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>				d. STREET ADDRESS <u>2500 Van Dorn Street</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Robert Keith Barton</u>				4 DATE OF DEATH Month Day Year <u>5 30 1967</u>			
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1-22-1936</u>	9 AGE (In years last birthday) <u>31</u> yrs	10 UNDER 1 YEAR Months Days Hours Min		11 UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EMPLOYEE-RCA CORP.</u>		10b K NO OF BUSINESS OR INDUSTRY <u>RCA CORPORATION</u>		11 BIRTHPLACE (State or foreign country) <u>FAIRBOLT MINNESOTA</u>		12 CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>	
13 FATHER'S NAME <u>HERBERT BARTON</u>				14 MOTHER'S MAIDEN NAME <u>LEULLA TYSLAND</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) (If yes give war or dates of service) <u>YES</u>		16 SOCIAL SECURITY NO		17 INFORMANT <u>MRS. LEULLA TYSLAND (Mother) BARTON</u>		Address <u>Mason City, Iowa</u> <u>2020 S. HARDING STREET</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Laceration of brain</u> DUE TO <u>Trauma - auto accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS A TOLPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Pedestrian struck by car.</u>					
20c TIME OF INJURY Month Day Year Hour a.m. p.m. <u>5:01pm 5-30-1967</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>53rd. Pl. & Marlboro Pike, Prince George Co.</u>		20f City or town (County) (State) <u>Prince George's Co. (County) (State)</u>	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>5-31-67</u>	
23a BURIAL/CREMATION REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>JUNE 3, 1967</u>		23c NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK CEMETERY</u>		23d CATION City Town (County) (State) <u>MASON CITY, IOWA</u>	
24 FUNERAL DIRECTOR <u>WASH. D.C. ADDRESS</u> <u>HYSON'S FUNERAL HOME 1300 N. STREET, N.W.</u>				25a RECD BY REGISTRAR <u>JUN 2 1967</u>		25b REGISTRAR'S SIGNATURE <u>J. M. Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

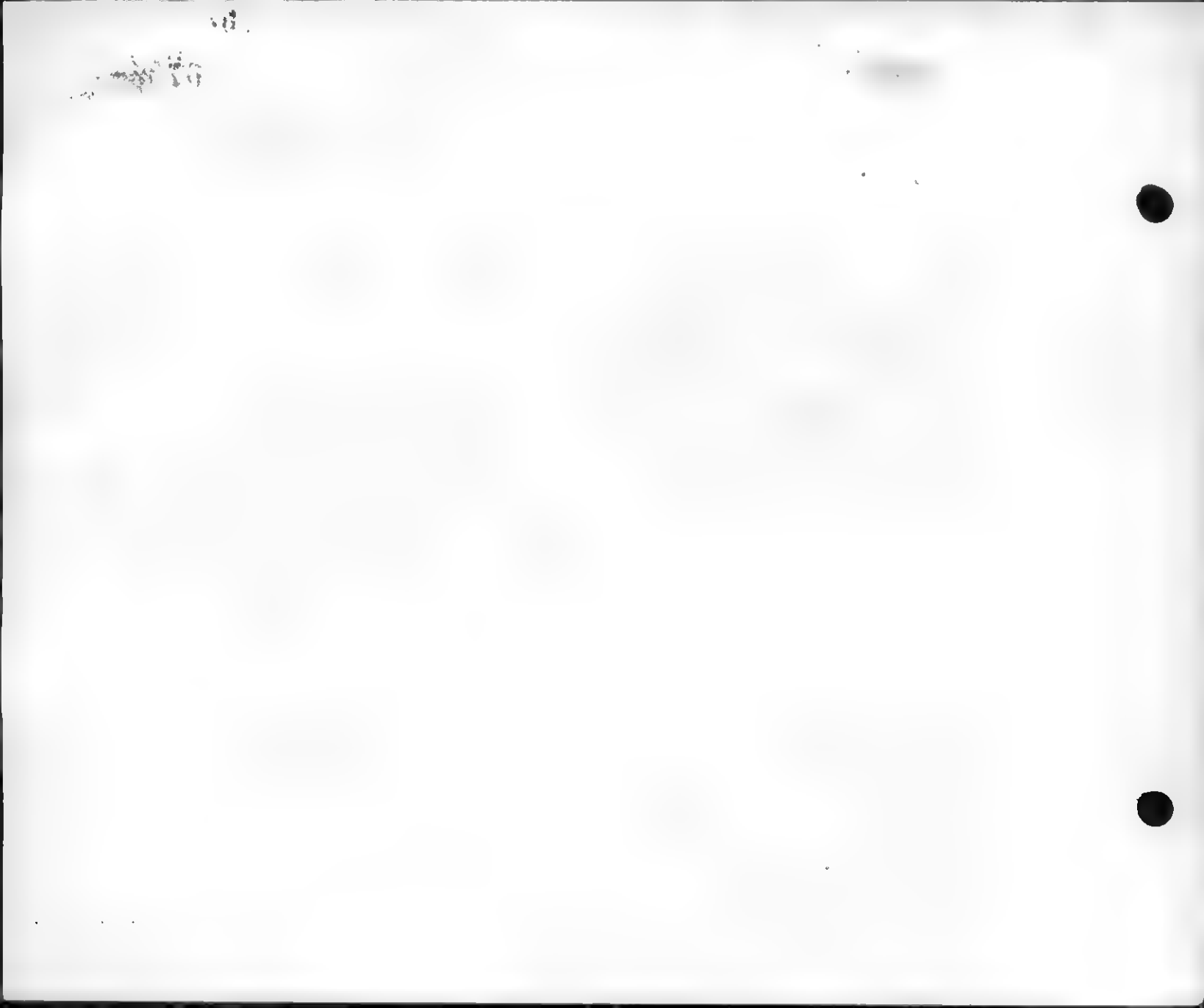
07037

CERTIFICATE OF DEATH

07020

1 PLACE OF DEATH a COUNTY Prince George b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c LENGTH OF STAY in 1b Edmonston d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Prince George c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edmonston d STREET ADDRESS 5113 Decatur St., e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Fannie Lee Barwick 4 DATE OF DEATH Month Day Year 5 19 67		5 SEX Female 6 COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 4-15-86 9 AGE (In years last birthday) 81 IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during last 12 months, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Own Home 11 BIRTHPLACE (County & State, or foreign country) Virginia 12 CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Weston Thomas Graves 14. MOTHER'S MAIDEN NAME Betty Hunt	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no 16 SOCIAL SECURITY NO. 215 54 1147 17. INFORMANT Daughter & Medical Records Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Concussion heart failure</i> 4200 DUE TO <i>arterio sclerosis heart dis. 2 yrs.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <i>General arterio sclerosis</i> (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 4-29-67, 1967, to 5-19-67, 1967, that (I) (we) last saw the deceased alive on May 18, 1967, and that death occurred at 8:22 A.M. from causes and on the date stated above. 22a SIGNATURE <i>L W Malin</i> M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <i>Dr L. W. Malin, M.D.</i> 22d ADDRESS 4404 Queensbury Rd., Riverdale, Md. 22b. DATE SIGNED 5-19-67	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial 23b DATE THEREOF 5/22/67 23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln 23d LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.		24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md. 25a REC'D BY REGISTRAR MAY 22 1967 25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07033

07021

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived) (Institutional Residence (If Institution)) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George General Hospital				e. STREET ADDRESS 11605 35th. Ave.			
3 NAME OF DECEASED (Type or print) First Gerald Middle Ray Last Bath				4 DATE OF DEATH Month 5 Day 15 Year 19 67			
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11-14-1950	9 AGE (In years last birthday) 16 yrs	IF UNDER 1 YEAR Months 5 Days 15	IF UNDER 24 HRS Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Public School		11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ray J. Bath				14 MOTHER'S MAIDEN NAME Irsi C. Huskey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Ray J. Bath			Address 11605 35th Avenue Beltsville, Maryland
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hanging 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Hung self with necktie in attic bedroom of home.					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1:00am p.m. 5-15- 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) home		20f. (City or town) (County) (State) same as #2		
21. I certify that I took charge of the remains described above and an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME (Type) John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 5-15-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 18, 1967		23c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery		23d. LOCATION City or Town (County) (State) Adelphi, Maryland	
24. FUNERAL DIRECTOR Glen Carter		25a. ADDRESS 8434 Georgia Avenue Silver Spring, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAY 18 1967	



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07039

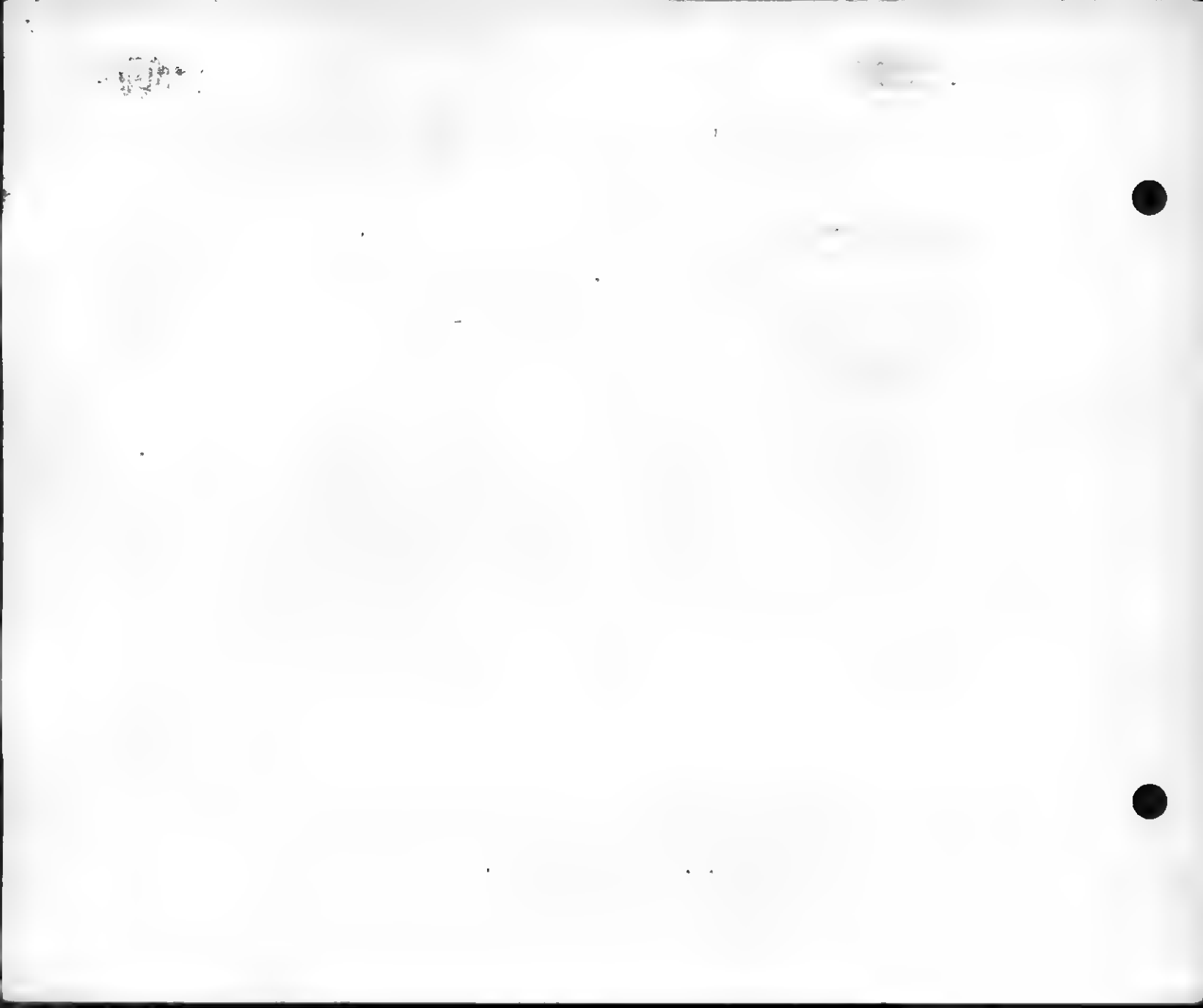
07022

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN TB DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) William T. Barrett				4 DATE OF DEATH 5 12 19 67			
5 SEX male		6. COLOR OR RACE white		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-6-1887	
9 AGE (In years, last birthday) 80 yrs		10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Nurseman		10b. KIND OF BUSINESS OR INDUSTRY self		11. BIRTHPLACE (State or foreign country) Maryland	
13 FATHER'S NAME Henry G Barrett				14 MOTHER'S MAIDEN NAME Unknown			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16 SOC. A. SECURITY NO.		17 INFORMANT Lester A Barrett Address Mt Rainier, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH minutes unknown
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D. EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				22. DATE SIGNED 5-13-67			
23a. BURIAL, CREMATION, REMOVAL, SPECIFY Burial		23b. DATE THEREOF May 16, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or town) (County) (State) Colmar Manor Pro Geo Md.	
24 FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR MAY 17 1967		25b. REGISTRAR'S SIGNATURE Charles J. Jones	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

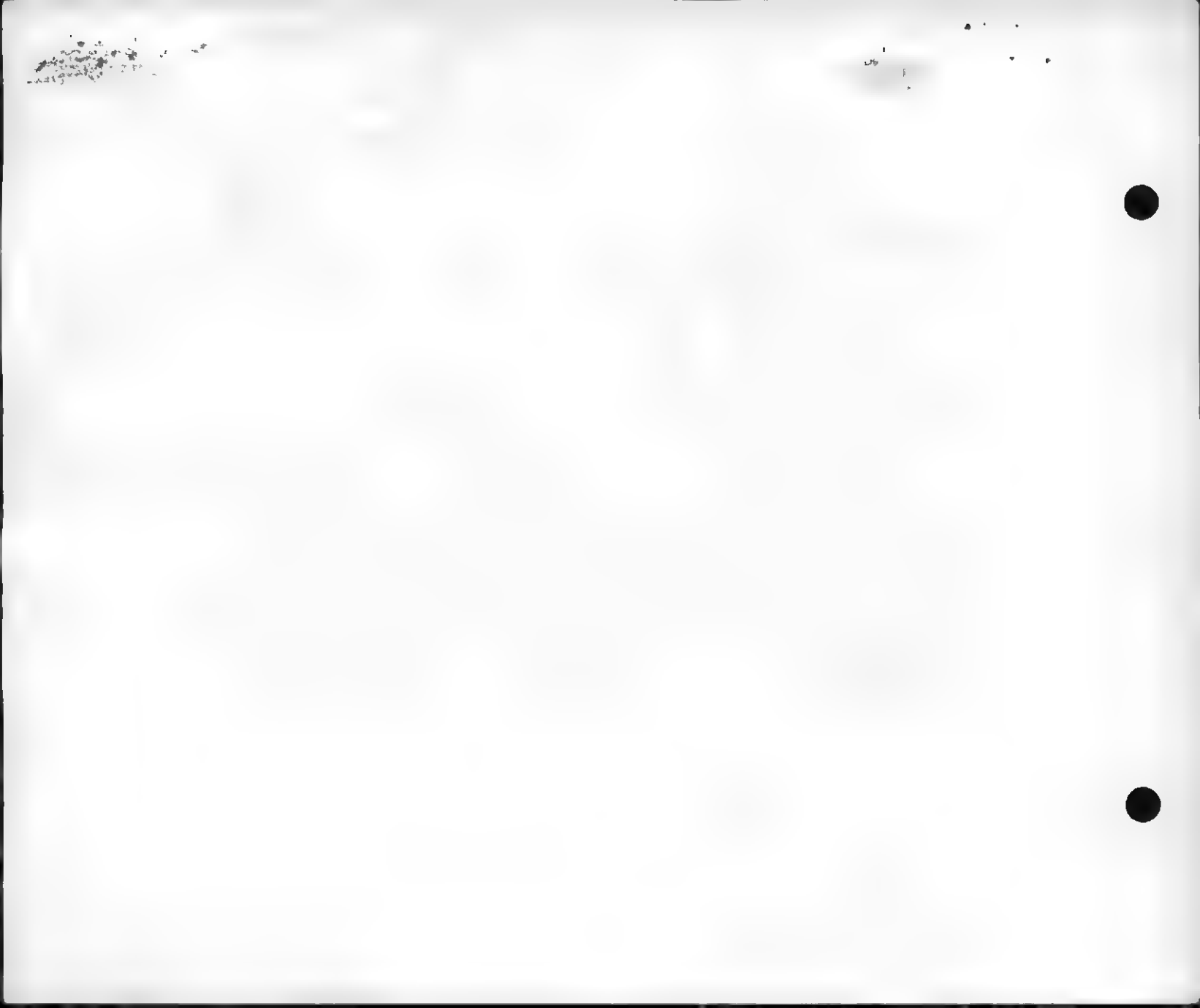
07041

07024

1 PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Clinton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Morningside</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Southern Md. Hospital</i>		d. STREET ADDRESS <i>204 Woodland Rd.</i>	
3. NAME OF DECEASED (Type or print) First <i>Hazel</i> Middle <i>E.</i> Last <i>Beach</i>		4 DATE OF DEATH Month <i>MAY</i> Day <i>9</i> Year <i>1967</i>	
5 SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>3-13-1912</i>
9 AGE (in years last birthday) <i>55</i> yrs		IF UNDER 1 YEAR Months <i>5</i> Days <i>18</i> Hours <i>15</i> Min <i>00</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>NORTH CAROLINA</i>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <i>Wiley Wiles</i>		14 MOTHER'S MAIDEN NAME <i>Lockie HAM</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.	
17. INFORMANT <i>Robert H. Beach - Same As Item 2</i>		18. ADDRESS <i>17</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO <i>Cerebrovascular accident</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive arteriosclerotic disease</i> (c) <i>20 days</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 hours</i>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <i>4-15</i> , 19 <i>67</i> , to <i>5-9</i> , 19 <i>67</i> that (I) (we) last saw the deceased alive on <i>5-9</i> , 19 <i>67</i> , and that death occurred at <i>1:50 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Alfred R. Lapin, M.D.</i>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <i>5-9-67</i>
22c. PHYSICIAN'S NAME (Type) <i>ALFRED R. LAPIN, M.D.</i>		22d. ADDRESS <i>Clinton, Md.</i>	
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>May 13-1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Ham Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Lansing, North Carolina</i>
24 FUNERAL DIRECTOR <i>Shannon Bros.</i>		ADDRESS <i>Silveryn Broc. 1661 Good Hope Rd SE Wash DC</i>	25a REC'D BY REGISTRAR <i>May 11 1967</i>
		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

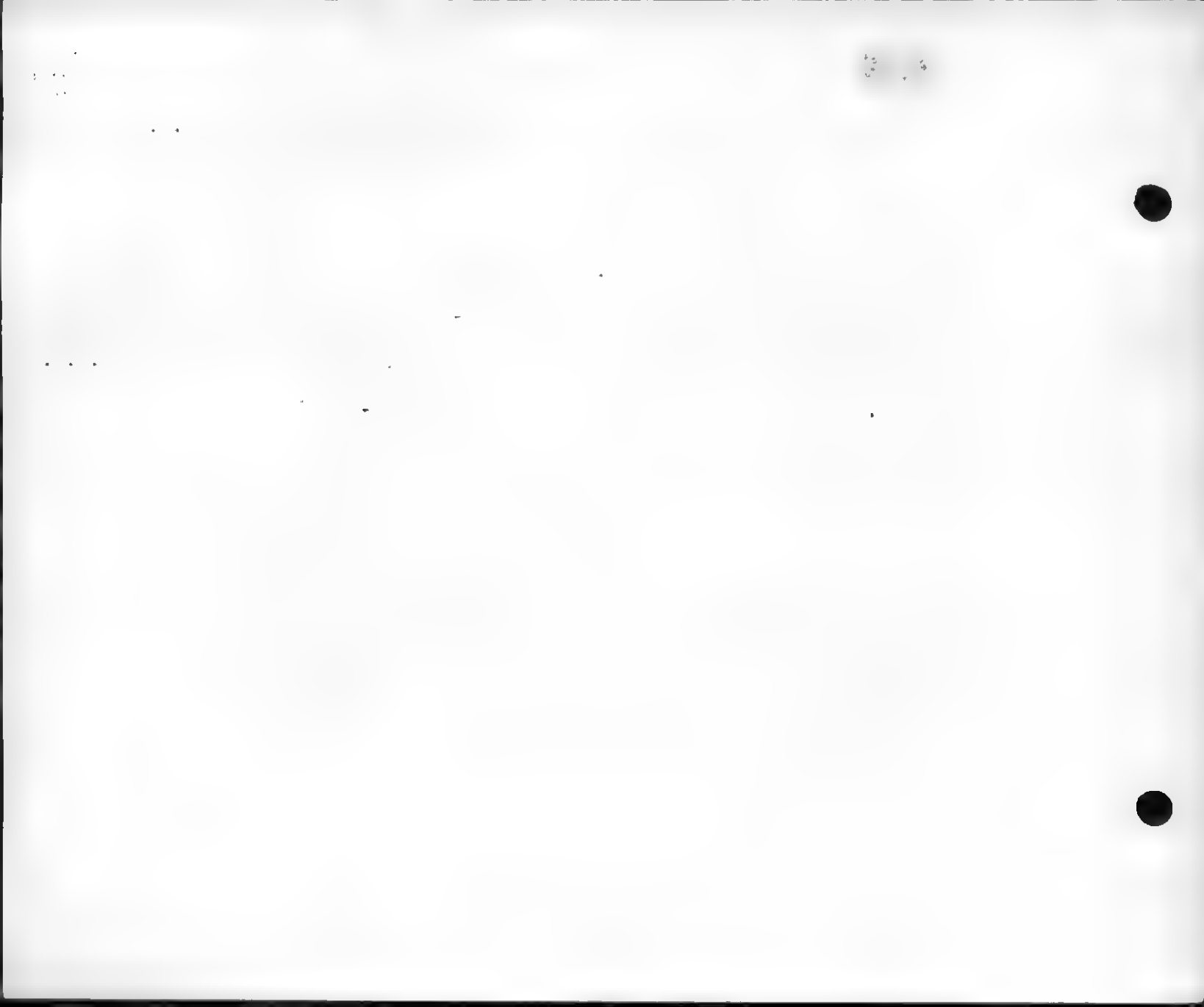
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07042

CERTIFICATE OF DEATH

08521

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY P.G.	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c LENGTH OF STAY IN 1b 36 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial		e STREET ADDRESS 1017 Ward St.	
3 NAME OF DECEASED (Type or print) First Leonard Middle GLUY Last Bedwell		4 DATE OF DEATH Month May Day 28 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5-23-03
9 AGE (In years lost birthday) 64 yrs		10 IF UNDER 1 YEAR Months 16 Days 1 Hours 1 Mins 1	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Race Horse Trainer		10b KIND OF BUSINESS OR INDUSTRY PUBLIC STABLE	
11 BIRTHPLACE (County & State, or foreign country) Colorado		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Harry G. Bedwell		14 MOTHER'S MAIDEN NAME Lotta L. Clark	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-16-2926	
17 INFORMANT hospital records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMATOSIS DUE TO (b) ADENOCARCINOMA OF COLON DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 3 mos. 1 YR
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour 19 a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-22 , 19 67 , to 5-28 , 19 67 , that (I) (we) last saw the deceased alive on 5-2 , 19 67 , and that death occurred at 10:25 P.M. from causes and on the date stated above.			
22a SIGNATURE C. J. Houmann		22b. DATE SIGNED 5-28-67	
22c PHYSICIAN'S NAME (Type) C. J. HOUMANN		22d ADDRESS RIVERDALE MD	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF 5-31-67	23c NAME OF CEMETERY OR CREMATORY Long Hill Cem.	23d LOCATION (City or Town) (County) (State) Laurel P.G. Md.
24 FUNERAL DIRECTOR William A. Donaldson		25a REC'D BY REGISTRAR JUN 15 1967	
25b REGISTRAR'S SIGNATURE J. Charles Jones			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH

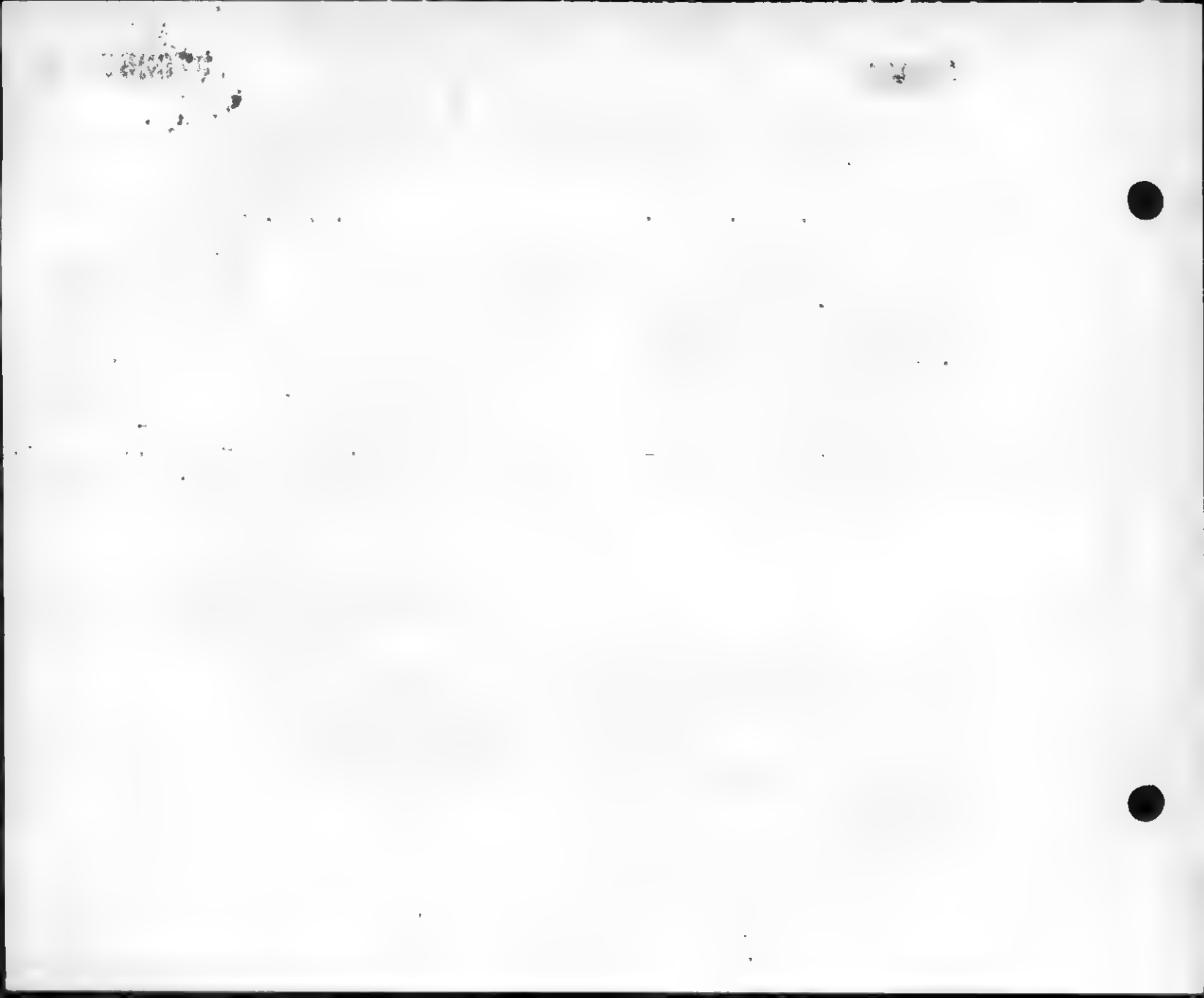
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07043

07025

1. PLACE OF DEATH a. COUNTY Prince George				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland				b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 4 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Geo. Gen. Hosp.				d. STREET ADDRESS Rt. 2 - R.F.?D. - Box 2744				e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
3. NAME OF DECEASED (Type or print) First: Sena Middle: M. Last: Bindig				4. DATE OF DEATH Month: May Day: 17 Year: 1967							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/17/1897		9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months: Days: Hours: Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Post Office				10b. KIND OF BUSINESS OR INDUSTRY Retired				11. BIRTHPLACE (County & State, or foreign country) Utah		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Thompson				14. MOTHER'S MAIDEN NAME Maria Peterson							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 121-03-8757		17. INFORMANT Mrs. Martha E. Krueger - Blvd. Hankato.				Address 107-Marie	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 31X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Cerebral Arteriosclerosis (c) DUE TO				(Sister-in-law) Minn. INTRA CEREBRAL HEMORRHAGE				INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5-14-1967 to 5-17-1967, that (I) (we) last saw the deceased alive on May 17, 1967, and that death occurred at 2:30 PM, from the causes and on the date stated above.											
22a. SIGNATURE Deymen S. Miller MD						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-18-67			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5/19/67		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.				23d. LOCATION (City, town or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.				ADDRESS Maryland		25a. REC'D BY REGISTRAR DATE MAY 22 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL (ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 is to be retained by the hospital or attending physician. Page 2 is to be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly
c. LENGTH OF STAY IN b 9 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges Gen. Hosp
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Mary C. Bivens

5. SEX F

6. COLOR OR RACE W

7. MARRIED ☐ NEVER MARRIED ☐ B. DATE OF BIRTH 12-21-79

WIDOWED ☒ DIVORCED ☐

8. DATE OF DEATH May 21 1967

9. AGE (in years last birthday) 87 yrs.

10. UNDER 24 HRS. Months Days Hours M'n.

11. BIRTHPLACE (County & State, or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Loveless

14. MOTHER'S MAIDEN NAME Matilda Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Catherine A. Downs

Address Same As I Item 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

DUO TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUO TO

cardiac arrest
arteriosclerotic heart disease
arteriosclerotic generalized

INTERVAL BETWEEN ONSET AND DEATH

1 hour

6 months

1 year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While ☐ Not While ☐ at work ☐ at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 1966 to 5/21/67, that (I) (we) last saw the deceased alive on 5/21/67, and that death occurred at 5/21/67, from the causes and on the date stated above.

22a. SIGNATURE

M.D.

ATTENDING PHYS. ☒

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED May 21-67

22c. PHYSICIAN'S NAME (Type) Dr. Leon R. Levitsky

22d. ADDRESS

3408--Rhode Island Ave Mt. Rainier Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE THEREOF May 24-1967

23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery

23d. LOCATION (City, town or county) Suitland, Maryland

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Signore Bros. 1661 Good Hope Rd SE Wash DC

25a. REC'D BY REGISTRAR MAY 23 1967

25b. REGISTRAR'S SIGNATURE

Charles Judge

1944

W128



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #24 Filed 5/16/67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

07045

07027

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE District of Columbia b COUNTY			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly				c LENGTH OF STAY in 1b			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1711 62nd. Avenue				e STREET ADDRESS 501 60th. St., N.E.			
3 NAME OF DECEASED (Type or print) Frederick William Blackford				4 DATE OF DEATH Month 5 Day 7 Year 19 67			
5 SEX male	6 COLOR OR RACE negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6-12-1936	9 AGE (in years lost birthday) yrs 30	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR				10b. KIND OF BUSINESS OR INDUSTRY RENTAL CAR CO.		11 BIRTHPLACE (State or foreign country)	
12 CITIZEN OF WHAT COUNTRY? USA				13 FATHER'S NAME HOWARD M. BLACKFORD			
14 MOTHER'S MAIDEN NAME ESTELLE P. CORAN				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN			
16 SOCIAL SECURITY NO				17 INFORMANT Address MRS. DOROTHY BLACKFORD 501 60TH ST. N.E.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound of chest 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Shot self in chest			
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 12:15 5-7- 19 67				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office, building, etc.) 1711 62nd. Ave., Cheverly, Maryland	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							22. DATE SIGNED 5-8-67
ACTUAL SIGNATURE John Kehoe, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county)			
23a. BURIAL CREMATION REMOVAL (Specify) 5-11-67				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY LINCOLN MEMORIAL CEMETERY	
23d. LOCATION city or town (County) (State) SUITLAND, MARYLAND				25a. REG'D BY REGISTRAR MAY 11 1967			
24 FUNERAL DIRECTOR C Dyson Funeral Home 3015 12th St., N.E.				25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07046		07028	
1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE New Mexico b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN TB D O A	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Almagorda		d. STREET ADDRESS 1616 Jefferson St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Gen. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edwin H. Boren		4. DATE OF DEATH Month 5 Day 17 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 May 1910
9. AGE (In years last birthday) 56 yrs		10. UNDER YEAR Months Days	11. UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of workable, even if retired) CIVILIAN		10b. KIND OF BUSINESS OR INDUSTRY U.S. AIR FORCE	
11. BIRTHPLACE (State or foreign country) TEXAS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES UNKNOWN UNKNOWN		16. SOCIAL SECURITY NO UNKNOWN	
17. INFORMANT RECORDS ANDREW AIR FORCE BASE		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO Arterio Sclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c)		INTERVAL BETWEEN ONSET AND DEATH min. unknown.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D. Riverdale, Md		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THIPPED 5/18/67	
23c. NAME OF CEMETERY OR CREMATORY FORT SAN HOUSTON		23d. LOCATION City, Town, County, State SAN ANTONIO, TEXAS	
24. FUNERAL DIRECTOR W.W. CHAMBERS CO. INC. WASH. D.C.		25a. REC'D BY REGISTRAR MAY 22 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge		22. DATE SIGNED 5-18-67	

11/11/11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert page 3 in the certificate. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07047

CERTIFICATE OF DEATH

03526

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 2hrs. 14 mins.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 5312 Riverdale Rd.			
3. NAME OF DECEASED (Type or print) First Middle Last Baby Girl Borrás				4. DATE OF DEATH Month Day Year May 28 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1967	9. AGE (In years last birthday) yrs	IF UNDER 18 Months Days	IF UNDER 24 HRS Hours Mins	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph Borrás				14. MOTHER'S MAIDEN NAME Barbara Ann Sparrough			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Anoxia</u> DUE TO <u>Prématurité</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Prématurité</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) <u>physician</u> attended the deceased from <u>May 28, 1967</u> , to <u>May 28, 1967</u> , that (I) <u>last</u> saw the deceased alive on <u>May 28, 1967</u> , and that death occurred at <u>1:30 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>John R. Buell</u>				22b. DATE SIGNED <u>5/29/67</u>			
22c. PHYSICIAN'S NAME (Type) John R. Buell, M. D.				22d. ADDRESS 8116 Gorman Ave. Laurel, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 6/10/67		23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp. Cheverly		23d. LOCATION (City or Town) (County) (State) PG Maryland	
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Admin., Cheverly, Maryland				25a. REC'D BY REGISTRAR JUN 14 1967		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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PG 4

4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07048

CERTIFICATE OF DEATH

07029

1 PLACE OF DEATH a COUNTY Prince George MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE New York b. COUNTY Westchester	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c LENGTH OF STAY IN 1b 11 mo. 6 days	
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Plains			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Home, 5805 Queens Chapel Road		d. STREET ADDRESS 50 North Broadway	
3 NAME OF DECEASED (Type or print) First Middle Last Eva Fidelis Brady		4. DATE OF DEATH Month Day Year May 21 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH January 1, 1885
9 AGE (In years last birthday) 82		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	
10b. KIND OF BUSINESS OR INDUSTRY own Home		11. BIRTHPLACE (County & State, or foreign country) New York, N.Y.	
12 CITIZEN OF WHAT COUNTRY? United States			
13 FATHER'S NAME John Barrett		14 MOTHER'S MAIDEN NAME Nellie Angers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16 SOCIAL SECURITY NO 044-05-4915	
17. INFORMANT Address Sacred Heart Home, Hyattsville, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Coronary Occlusion</i> DUE TO <i>Chronic Cardiac Vascular Disease</i> DUE TO <i>Sclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/16/66 1967 to 5-20 1967 that (I) (we) last saw the deceased alive on 5-20 1967, and that death occurred at 5:10 P.M. from causes and on the date stated above.			
22a. SIGNATURE Robert C. Haile		22b. DATE SIGNED 5-22-67	
22c. PHYSICIAN'S NAME (Type) Robert C. Haile		22d. ADDRESS 35 NY AVE NW WASH DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-25-67	
23c. NAME OF CEMETERY OR CREMATORY St. Peters		23d. LOCATION (City or Town) (County) (State) Danbury, Connecticut	
24 FUNERAL DIRECTOR GASCH'S		25. RECEIVED BY REGISTRAR MAY 24 1967	
4739 Baltimore Ave. Hyattsville, Maryland		25b. REGISTRAR'S SIGNATURE [Signature]	

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11/10/00
in

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07043

07030

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Pro Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carrollton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 5814 Lamont Drive	
3 NAME OF DECEASED Filippa, Maria ^{First} Eugenia DiGregorio ^{Middle} Brancato ^{Last} (Type or print)		4. DATE OF DEATH Month May Day 5, Year 19 67.	
5 SEX female	6. COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 29, 1889
9 AGE (In years last birthday) yrs 77		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	
10b. KIND OF BUSINESS OR INDUSTRY own home		11 BIRTHPLACE (County & State, or foreign country) Palermo, Italy	
13 FATHER'S NAME Pasquale DiGregorio		14 MOTHER'S MAIDEN NAME Ignazia Buscemi	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO.	
17 INFORMANT Settimo E Brancato		Address Carrollton, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>leukemia</u> 6000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Bilateral pyonephrosis</u> DUE TO (c) <u>Rt pyonephrosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-4, 1965, to 5-6, 1967, that (I) (we) last saw the deceased alive on 5-6, 1967, and that death occurred at 4:30 M, from causes and on the date stated above.			
22a. SIGNATURE <u>George Hageage</u>		22b. DATE SIGNED 5-8-67	
22c. PHYSICIAN'S NAME (Type) George Hageage		22d. ADDRESS Cottage City, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 9, 1967	23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Washington D. C.
24 FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR MAY 10 1967	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Fillen please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

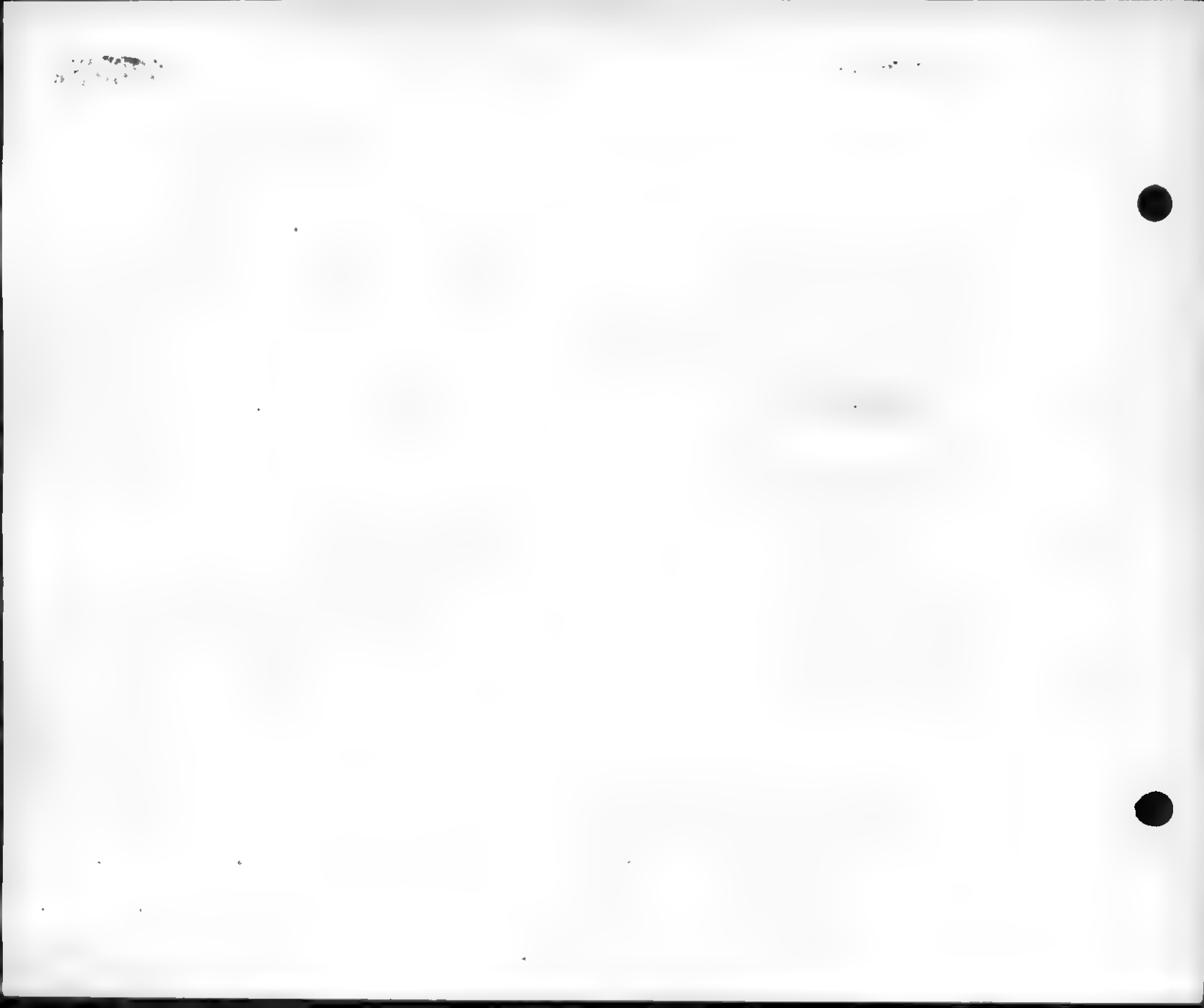
07050

CERTIFICATE OF DEATH

07031

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b Hyattsville d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission): a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 3700 Oliver St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Robert Broadwater		4. DATE OF DEATH Month Day Year 5-19-1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1916
9. AGE (In years last birthday) 51 yrs		10. IF UNDER 1 YEAR Months Days Hours Min 51	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 1st Methodist Church		10b. KIND OF BUSINESS OR INDUSTRY Bldg. Superintendant	
11. BIRTHPLACE (County & State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert S. Edden		14. MOTHER'S MAIDEN NAME Hildegard Merkle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO Medical Records & Pre-admission chart	
17. INFORMANT Medical Records & Pre-admission chart		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-pulmonary failure 1905 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) METASTATIC CARCINOMA lung (c) MALIGNANT MELANOMA - Back		INTERVAL BETWEEN ONSET AND DEATH 3 mo 18 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) APRIL		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 13 mo, 1966 , to 5-19-67 , 19__, that (I) (we) last saw the deceased alive on 5-19-67 19__, and that death occurred at 1:20 PM , from causes and on the date stated above.			
22a. SIGNATURE R. F. Wilkinson		22b. DATE SIGNED 5-19-67	
22c. PHYSICIAN'S NAME (Type) R. F. Wilkinson, M.D.		22d. ADDRESS 4404 Queensbury Rd., Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/22/67	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR MAY 22 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07051

07032

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN It DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital		d STREET ADDRESS 2515 Jameison Street	
3 NAME OF DECEASED (Type or print) First Frederick Middle Thomas Last Brooks		4 DATE OF DEATH Month May Day 14 Year 1967	
5 SEX male	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 25, 1940
9 AGE (In years last birthday) 26		10 UNDER 1 YEAR Months 14 Days 14 Hours 14 Min 14	
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Biologist		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) North Carolina		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME James Brooks		14 MOTHER'S MAIDEN NAME Floaia Walker	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16 SOCIAL SECURITY NO	
17 INFORMANT Mary E. Brooks-wife		Address 2515 Jameison	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Laceration of right carotid artery DUE TO (c) Trauma - auto accident			INTERVA. BETWEEN ONSET AND DEATH minutes minutes
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PR. MARY <input checked="" type="checkbox"/> CONTR. BUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Driver of car which went out of control and struck house.	
20c TIME OF INJURY Month, Day, Year Hour a.m. 5:33AM p.m. 5-14-67 19		20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	
20e PLACE OF INJURY Home form factory, street, off. bldg, etc. 100 ft. s. of Catskill St. P.G.		20f (City or town) (County) (State) 100 ft. s. of Catskill St. P.G.	
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 5-14-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a BURIAL CREMATION REMOVAL (Specify) Burial		23b DATE THEREOF 5/18/67	
23c NAME OF CEMETERY OR CREMATORY Lincoln Memorial Ceme.		23d LOCATION (City or town) (County) (State) Maryland	
24 FUNERAL DIRECTOR Stewart Funeral Home-4001 Benning Rd.,		25a RECEIVED BY REGISTRAR MAY 17 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

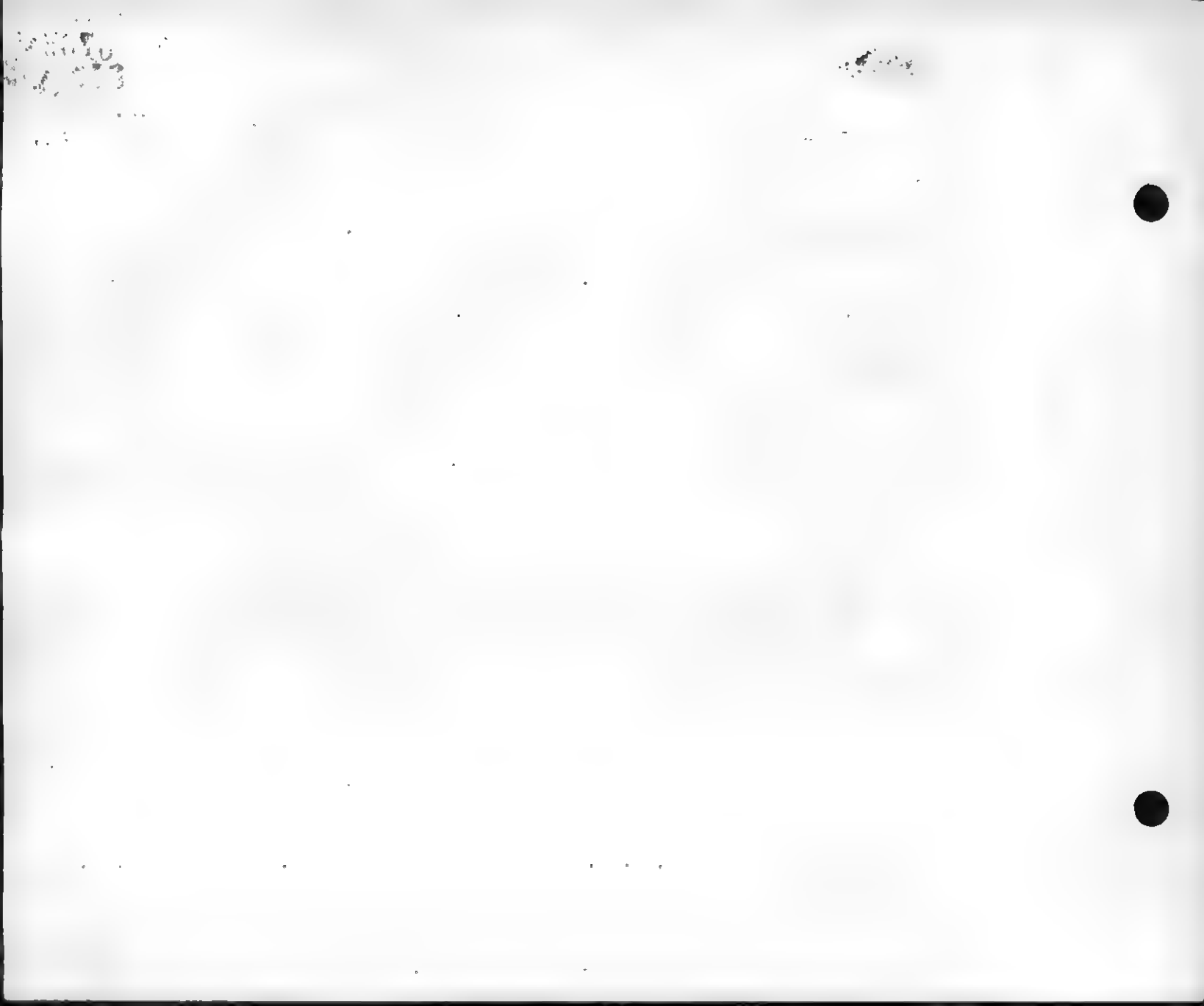
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07052

CERTIFICATE OF DEATH

07033

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 50 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 303 Hill Rd.		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last Albert B. Brown			4. DATE OF DEATH Month Day Year May 2, 19 67		
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5/23/76	9 AGE (In years lost birthday) 90 yrs	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11 BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Richard Brown			14. MOTHER'S MAIDEN NAME Judith -		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO		17. INFORMANT Address Iva M. Brown-wife Same as #2	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident. DUE TO (b) Anticoagulant Couder - DUE TO (c) Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					INTERVAL BETWEEN ONSET AND DEATH 2 weeks 10 yrs
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 6, 1952 , to May 2, 1967 , that (I) (we) last saw the deceased alive on May 2, 1967 , and that death occurred at 11:30 A.M. from causes on and on the date stated above.					
22a. SIGNATURE William Brainin M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. AM DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 5/2/67	
22c. PHYSICIAN'S NAME (Type) William Brainin, M. D.		22d. ADDRESS 6124 Central Ave. Capitol Hgts. Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-5-67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland Md.	
24. FUNERAL DIRECTOR Lee Funeral Home		ADDRESS 300 4th St. N.E. Wash., D.C.		25a. REC'D BY REGISTRAR MAY 5 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07053

07034

1 PLACE OF DEATH a. COUNTY PRINCE GEORGES COUNTY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS.		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUITLAND d. STREET ADDRESS 4824 EASTERN LANE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) BROWN, NORMAN. L.		4 DATE OF DEATH Month 28 Day MAY Year 1967	
5 SEX M	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 20 Aug 26
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US ARMY (RETIRED)		10b KIND OF BUSINESS OR INDUSTRY CIVIL SERVICE	9 AGE (In years lost birthday) 40 yrs
11. BIRTHPLACE (County & State, or foreign country) PINEVILLE, IA		12 CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME WILLIAM A. BROWN		14 MOTHER'S MAIDEN NAME LONIA HUNNICUT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16. SOCIAL SECURITY NO 437303533	17. INFORMANT DOROTHY S. BROWN-WIFE-SAME AS #2 Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) None Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 28 May, 1967 , to 28 May, 1967 , that (I) (we) last saw the deceased alive on 28 May, 1967 , and that death occurred at 2005 AM , from causes and on the date stated above.			
22a SIGNATURE Richard J. Wisley M.D.		22b DATE SIGNED 28 May 1967	
22c PHYSICIAN'S NAME (Type) RICHARD J. WISELEY, CAPT (MC)		22d ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB, WASHINGTON DC 20331	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF June 1967	23c NAME OF CEMETERY OR CREMATORY Alexandria Louisiana	23d LOCATION (City or Town) (County) (State) Alexandria, Louisiana
24 FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland		25a REC'D BY REGISTRAR DATE MAY 31 1967	25b REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

455-10

10-10-10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

07054

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07035

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 5 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University, Park		d. STREET ADDRESS 4002 Beachwood Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Sarah Middle Betty Last Brown		4 DATE OF DEATH Month 5 Day 25 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 24, 1877
9 AGE (in years last birthday) 89 yrs		10 UNDER 1 YEAR Months 5 Days 25 Hours 19 Min 67	11 BIRTHPLACE (County & State, or foreign country) New York
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11 BIRTHPLACE (County & State, or foreign country) New York		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Oscar Hinricks		14. MOTHER'S MAIDEN NAME Mary Stanley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Elizabeth Henson		Address Same as #2 (daughter)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4:00 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Generalized arteriosclerosis (b) (c) PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVA. BETWEEN ONSET AND DEATH 5 days year			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1965 , to 5-25, 1967 that (I) (we) last saw the deceased alive on 5-25 1967 , and that death occurred at 9:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Donald C. Edgren M.D.		22b. DATE SIGNED 5-26-67	
22c. PHYSICIAN'S NAME (Type) DONALD C. EDGREN		22d. ADDRESS Hyattsville, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Cremation	5/29/67	Ft. Lincoln	Colmar Manor P.G. Md.
24. FUNERAL DIRECTOR Francis Gasch's Sons		25a REC'D BY REGISTRAR MAY 31 1967	
ADDRESS Hyattsville, Md.		25b REGISTRAR'S SIGNATURE J. Charles Judge	

250

250



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item # 07055 & 07036 # 33-35/15/67 pc
CERTIFICATE OF DEATH

07055

07036

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 14 hrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 4012 Chelmont Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle K Last Buch				4. DATE OF DEATH Month May Day 10 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 Aug., 1888	9. AGE (In years last birthday) 77 78	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) Lancaster Co., Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Fenninger				14. MOTHER'S MAIDEN NAME Amanda Krider			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 173-03-1543D		17. INFORMANT Mrs. William H. Clifford		Address 4012 Chelmont Ln Bowie, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Edema 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Myocardial Infarction DUE TO (c) Septicemia Pericarditis Pleuritis Meningitis							INTERVAL BETWEEN ONSET AND DEATH 1 day.
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) A. Diabetes Mellitus B. Chronic Renal Disease							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from SEPT , 19 65 to May 10 , 1967, that (I) (we) last saw the deceased alive on May 10 , 1967, and that death occurred at 9, 15PM from causes and on the date stated above							
22a. SIGNATURE Norman K Bohrer M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED May 11, 1967.	
22c. PHYSICIAN'S NAME (Type) Norman K. Bohrer, M. D.				22d. ADDRESS 3231 Superior Lane, Bowie, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 5/13/1967		23c. NAME OF CEMETERY OR CREMATORY East Harrisburg		23d. LOCATION (City or town) (County) (State) Harrisburg, Dauphin, Penna.	
24. FUNERAL DIRECTOR Walter J. [unclear]				25a. RECD BY REGISTRAR MAY 15 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

1971

1972

1973

1974

1975



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07056

CERTIFICATE OF DEATH

07037

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Southern Maryland Medical Center				d. STREET ADDRESS 10611 - Brandywine Road			
3. NAME OF DECEASED (Type or print) First MICHAEL Middle T. Last BUCKLER				4. DATE OF DEATH Month May Day 26 Year 1967			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19-1907	9. AGE (In years last birthday) 59 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	10. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) US. Gov.		10b. KIND OF BUSINESS OR INDUSTRY Agricultural Dept.		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. C TIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Philip A. Buckler				14. MOTHER'S MAIDEN NAME Delphine Marr			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Evelyn E. Buckler (Wife) Address Same as # 2.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) CEREBROVASCULAR ACCIDENT DUE TO (c) HYPERTENSIVE ARTERIOSCLEROTIC						INTERVAL BETWEEN ONSET AND DEATH 3 MIN. 7 DAYS 10 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I None						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) None		20c. TIME OF INJURY Month Day Year None		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) None		20f. (City or town) (County) (State) None		21. I certify that (a) (this hospital) attended the deceased from May 19, 1967 to Present that (b) (we) last saw the deceased alive on May 26, 1967 , and that death occurred at 8:15 P.M. from causes and on the date stated above.			
22a. SIGNATURE Arthur Shaver Jr. MD				22b. DATE SIGNED 5/26/67		22c. PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 29th 67		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION (City or town) (County) (State) Clinton, Maryland	
24. FUNERAL DIRECTOR Simmons Bros.				25a. REC'D BY REGISTRAR MAY 31 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

100



FOR STATE
HEALTH DEPT.

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

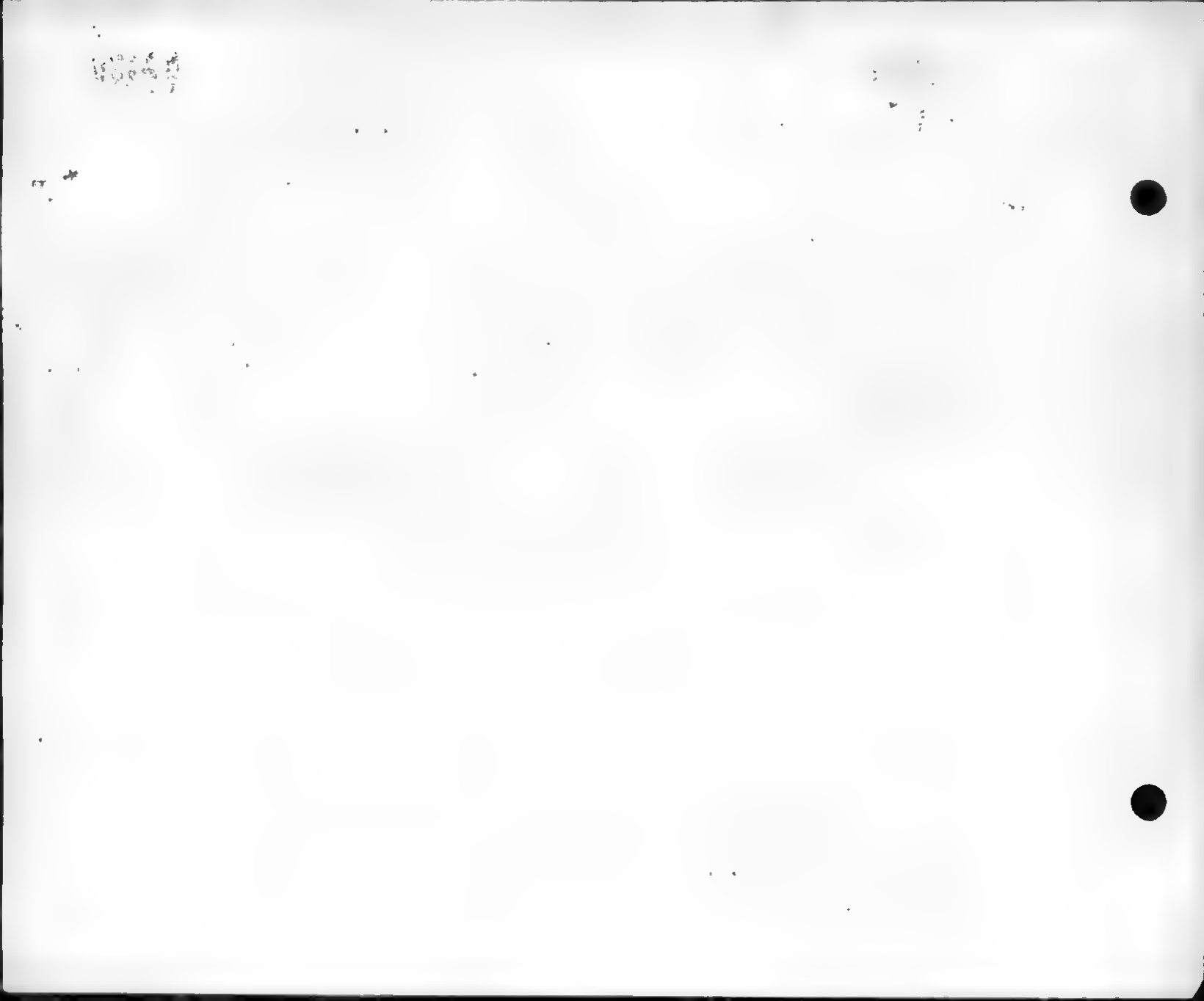
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07057

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07038

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE D.C. b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN 1b DOA	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C.
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d STREET ADDRESS 1838 Maryland Avenue	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last Edward Burch		4 DATE OF DEATH Month Day Year 5 27 19 67	
5 SEX male	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12-25-08
9 AGE (In years last birthday) 58 yrs		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shear Operator		10b KIND OF BUSINESS OR INDUSTRY Steel Fabricated Corp.	11 BIRTHPLACE (State or Country) Marion County, S.C.
12 CITIZEN OF WHAT COUNTRY? U.S.		13 FATHER'S NAME Charlie Burch	
14 MOTHER'S MAIDEN NAME Etta Davis (Burch)		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes 4/26/1942	
16 SOCIAL SECURITY NO 249-42-0220		17 INFORMANT Marie Leonard Burch	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laceration of brain DUE TO (b) Trauma - auto accident DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) driver of car involved in collision	
20c TIME OF INJURY Month, Day, Year 3:15am p.m. 5-27- 19 67		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) Woodrow Wilson Bridge, Prince George's, Md.		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
22 DATE SIGNED 5-27-67			
23a BURIAL PERMITTED 23b DATE THEREOF June 4 1967		23c NAME OF CEMETERY OR CREMATORY Church	
23d LOCATION (City or Town) (County) (State) Marion S.C.		23e REC'D BY REGISTRAR JUN 1 1967	
24 FUNERAL DIRECTOR E.T. Murray		25 REGISTRAR'S SIGNATURE John's Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07058

CERTIFICATE OF DEATH

07039

1 PLACE OF DEATH a. COUNTY <i>Prince Georges</i>			2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>			b. COUNTY <i>Prince Georges</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cheverly</i>			c. LENGTH OF STAY in 1b <i>D. O. A.</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince Georges General Hospital</i>						d. STREET ADDRESS <i>1400 Merrimac Drive</i>			
3 NAME OF DECEASED (Type or print) First <i>Benjamin</i> Middle <i>Smith</i> Last <i>Carrico</i>			4 DATE OF DEATH Month <i>May</i> Day <i>27</i> Year <i>1967</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5 SEX <i>Male</i>	6 COLOR OR RACE <i>white</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>Mar 2, 1895</i>	9. AGE (In years last birthday) <i>72</i> yrs	IF UNDER 1 YEAR Months <i> </i> Days <i> </i>		IF UNDER 24 HRS Hours <i> </i> Min. <i> </i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Clerk</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Grocery</i>		11 BIRTHPLACE (County & State, or foreign country) <i>Warrenton, Virginia</i>			12 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13 FATHER'S NAME <i>Silas Carrico</i>			14 MOTHER'S MAIDEN NAME <i>Dora Shaver</i>						
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO <i>577-10-9269</i>		17. INFORMANT <i>Mary E. Carrico</i>			Address <i>1400 Merrimac Drive Hyattsville, Maryland</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Cerebral Ischemia</i> <i>4201</i> DUE TO (b) <i>Coronary Artery Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Hypertension</i>								INTERVAL BETWEEN ONSET AND DEATH <i>9 Years</i> <i>12 Years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i> </i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>Nov. 1935</i> , to <i>May 27, 1967</i> , that (I) (we) last saw the deceased alive on <i>May 18, 1967</i> , and that death occurred at <i> </i> M, from causes and on the date stated above.									
22a. SIGNATURE <i>Lawrence J. Thomas</i>			M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22b. DATE SIGNED <i>May 29, 1967</i>			
22c. PHYSICIAN'S NAME (Type) <i>Lawrence J. Thomas</i>			22d. ADDRESS <i>1712 9. St., N. W., Washington, D. C.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 30, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Oakdale Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Manassas, Virginia</i>			
24 FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>			25a. RECEIVED BY REGISTRAR <i>Clark E. Buser</i> <i>8434 Georgia Avenue Silver Spring, Md.</i>			25b. REGISTRAR'S SIGNATURE <i>Judge</i>			

MEDICAL CERTIFICATION
Checked by Med Examiner

12/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

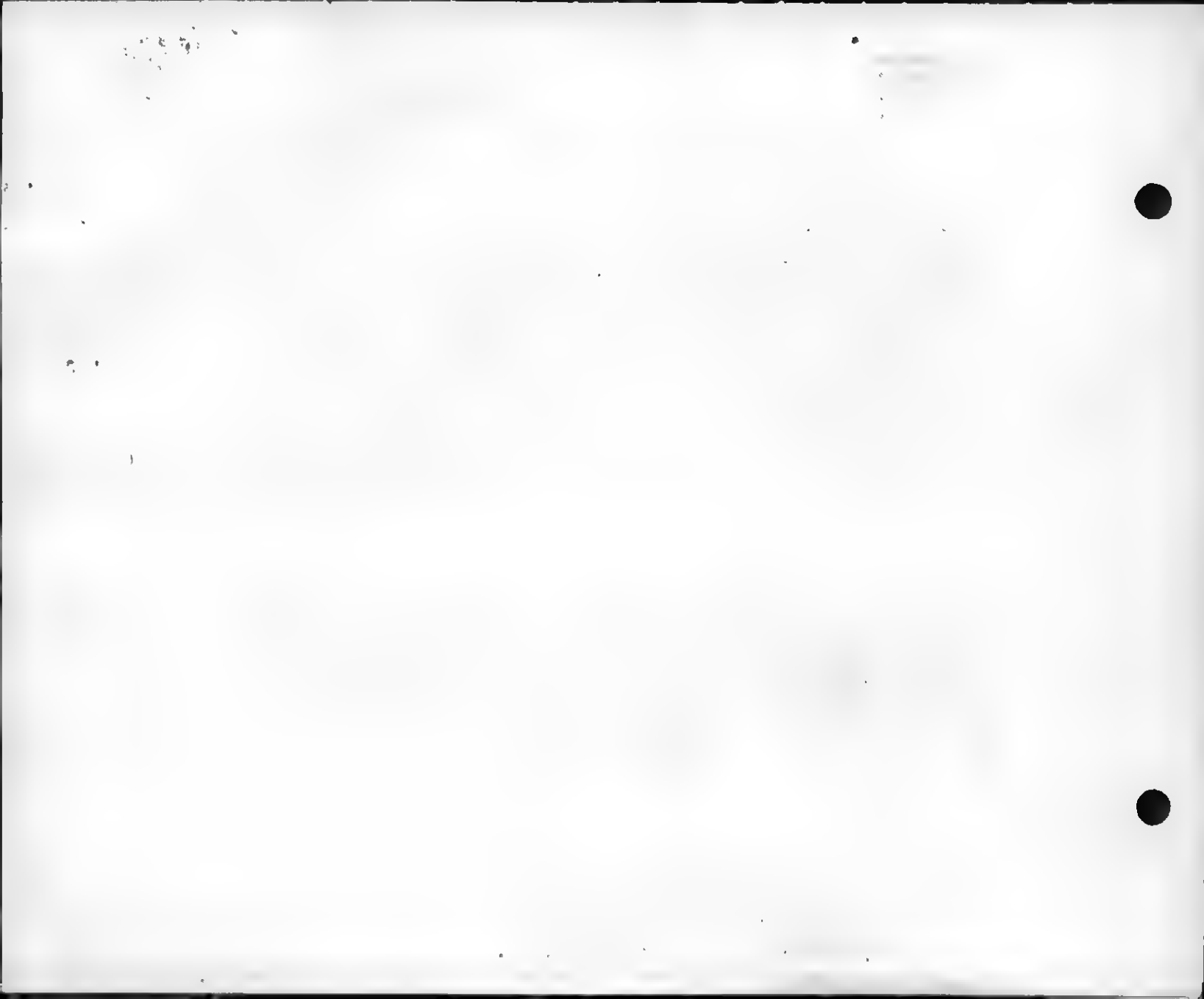
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07059

CERTIFICATE OF DEATH

07040

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greenbelt Convalescent Center		d. STREET ADDRESS 9607 48th Place	
3. NAME OF DECEASED (Type or print) ESTELLE E. CARROLL		4. DATE OF DEATH Month May Day 15 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 13, 1897
9. AGE (In years last birthday) 70 yrs		10. IF UNDER 1 YEAR Months 1 Days 15 Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Washington D C		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Charles B. Baker		14. MOTHER'S MAIDEN NAME Nabel Ingledue	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 577 07 5424B	
17. INFORMANT Herbert A. Carroll Same as #2 (husband)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO General Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Compulsive Neurosis		INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 10, 1967 to May 15, 1967 , that (I) (we) last saw the deceased alive on May 11, 1967 , and that death occurred at 11:05 M, from causes and on the date stated above.			
22a. SIGNATURE L W Malin		22b. DATE SIGNED 5-15-67	
22c. PHYSICIAN'S NAME (Type) L W MALIN M.D.		22d. ADDRESS Greenbelt, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 18, 1967	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

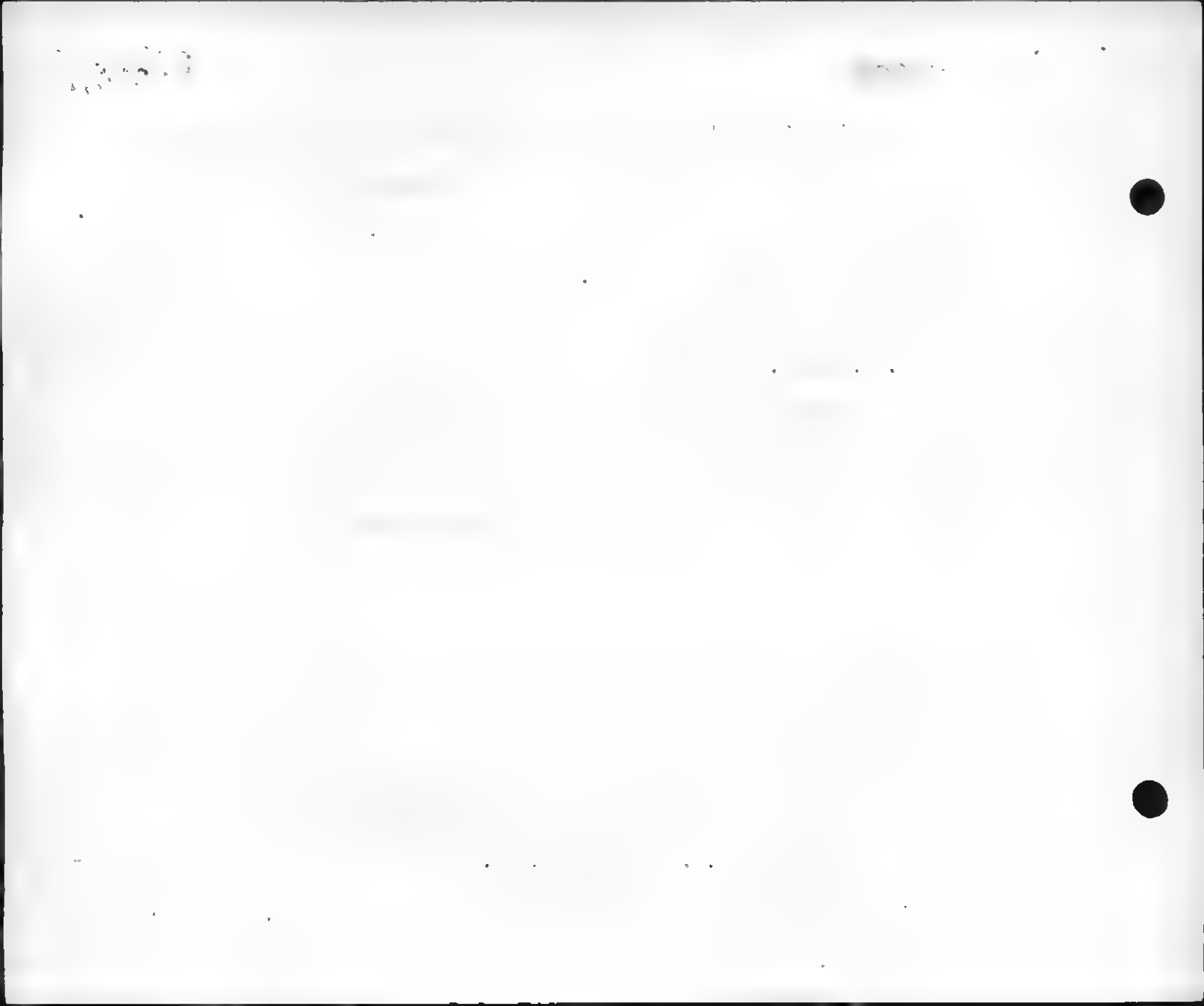
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07060

07041

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residec. before admission) a STATE Maryland b COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY in 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e STREET ADDRESS 5908 23rd. Place	
3. NAME OF DECEASED (Type or print) First Lee Middle G. Last Cary		4 DATE OF DEATH Month 5 Day 15 Year 19 67	
5. SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2 March 1907
9 AGE (In years last birthday) 60 yrs.		10 UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS <input type="checkbox"/> Months Days Hours Min	
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Gov't.		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Kentucky		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME Leslie Cary		14 MOTHER'S MAIDEN NAME Lula ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Edna M. Cary (Wife) Address Same as Item #2			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) (c) PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH minutes over 20 yrs	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D. EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED 5-15-67	
23a BURIAL CRIMATON REMOVAL (Specify) Burial	23b DATE THEREOF May 19-1967	23c NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d LOCATION City, town, county, (State) Louisville, Kentucky
24 FUNERAL DIRECTOR Simmons Bros.		25a REC'D BY REGISTRAR MAY 16 1967	25b REGISTRAR'S SIGNATURE Charles Judge
26 ADDRESS Simmons Bros. 1661-Good Hope Rd SE Wash DC			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07061

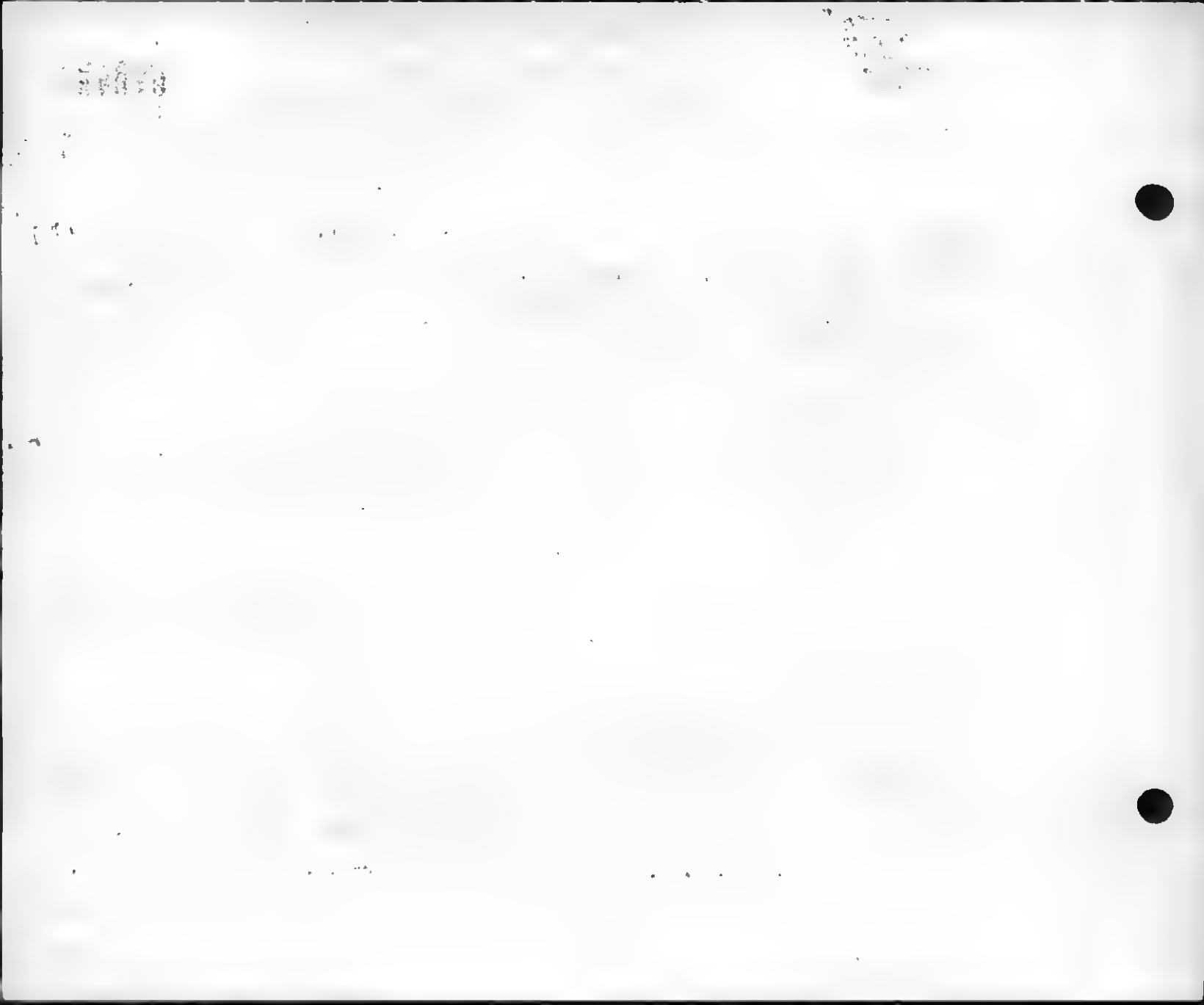
CERTIFICATE OF DEATH

07042

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 31 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 6309 Foote St.		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Baby Christine P. Caudill				4 DATE OF DEATH Month Day Year May 5 1967			
5 SEX Female		6 COLOR OR RACE white		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 4, 1967	
9 AGE (n years last birthday) 1+		IF UNDER 1 YEAR Months Days Hours Min. 1+		10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) Md Pro Geo County				12. CIT ZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Russell Caudill				14. MOTHER'S MAIDEN NAME Patrice H Hawes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Russell Caudill Address Seat Pleasant, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyaline membrane disease 1735 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) prematurity DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 31 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 4, 1967 , to May 5, 1967 that (I) (we) last saw the deceased alive on May 5, 1967 , and that death occurred at 1:30 P.M. from causes and on the date stated above.							
22a. SIGNATURE Milos Janga, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 5, 1967	
22c. PHYSICIAN'S NAME (Type) Milos Janga, M.D.				22d. ADDRESS 7403 Varnum St. Landover Hills, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 8, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons ADDRESS Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE MAY 8 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07062

CERTIFICATE OF DEATH

07043

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 52 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 6606 Fairwood Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last Robert J. Chamberlain				4 DATE OF DEATH Month Day Year May 28, 1967			
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8/13/03		9 AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. TREASURY		10b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT		11. BIRTHPLACE (County & State, or foreign country) WASH. D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert J. Chamberlain				14. MOTHER'S MAIDEN NAME BLANCH GARRETT			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 577-48-5871		17. INFORMANT Address SEE #2 Elsie E Chamberlain			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) circulatory failure 100X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) staph. abscess of lungs DUE TO (c) Diabetes mellitus.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour 'o m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 7, 1967 , to May 28, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 28, 1967 , and that death occurred at 1:10AM from causes and on the date stated above.							
22a. SIGNATURE B. Bahmani M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 29, 1967	
22c. PHYSICIAN'S NAME (Type) B. Bahmani M.D.				22d. ADDRESS 3003 Naylor Rd., E. D.C. 20020			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/1/67		23c. NAME OF CEMETERY OR CREMATORY Oakwood		23d. LOCATION (City or town) (County) (State) Falls Church, VA.	
24. FUNERAL DIRECTOR W. Chambers				ADDRESS Liverdale Rd.		25a. REC'D BY REGISTRAR DATE JUN 1 1967	
				25b. REGISTRAR'S SIGNATURE Thomas Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

101



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

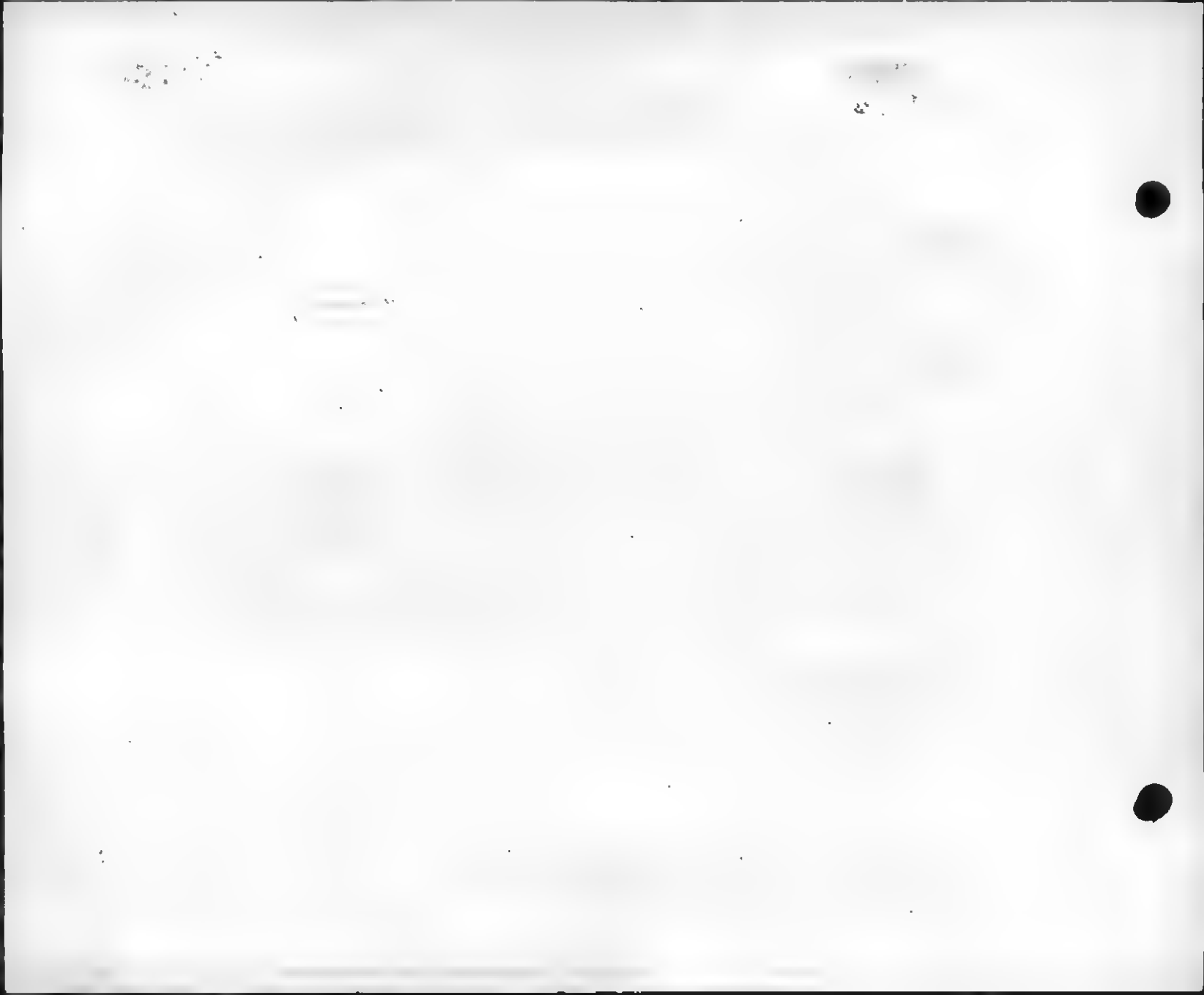
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07063

CERTIFICATE OF DEATH

07044

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Akon Hill</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Green Gardens</u>				d. STREET ADDRESS <u>5205 Sunnyside Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>H.</u> Last <u>Conklin</u>				4. DATE OF DEATH Month <u>May</u> Day <u>29</u> Year <u>1967</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>14</u> <u>1900</u>	
				9. AGE (In years last birthday) <u>66</u> yrs		10. F UNDER 1 YEAR Months <u>14</u> Days <u>14</u>	
						11. IF UNDER 24 HRS Hours <u>14</u> Min <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Peter Long</u>				14. MOTHER'S MAIDEN NAME <u>Dean Bell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO <u>578-24-8958-B</u>			
				17. INFORMANT <u>Joseph B Norris same as #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY <u>1992</u> IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO (b) <u>GENERALIZED CARCINOMATOSIS</u> DUE TO (c) <u>ABDOMINAL CARCINOMA</u>				INTERVAL BETWEEN ONSET AND DEATH <u>16 MIN.</u> <u>1 MONTH</u> <u>6 MONTHS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NONE</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>NONE</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>None</u> am <u>19</u> pm <u>19</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <u>None</u> at work <u>None</u>			
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>None</u>				20f. (City or town) (County) (State) <u>None</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>May 17, 1967</u> , to <u>Present</u> , that (I) (we) last saw the deceased alive on <u>May 28, 1967</u> , and that death occurred at <u>6:39</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Arthur Shaver Jr.</u>				22b. DATE SIGNED <u>5/29/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR. M.D.</u>				22d. ADDRESS <u>8808 OLD BRANCH AVE CLINTON, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5/31/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON NATIONAL</u>		23d. LOCATION (City or Town) (County) (State) <u>PRINCE GEORGES, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>ROBERT E. WILHELM</u> FUNERAL HOME <u>4308 SUTLAND ROAD, SUTLAND, MARYLAND</u>				25a. REC'D BY REGISTRAR <u>DATE MAY 31 1967</u>			
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08547

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, on any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Washington, D. C. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 42 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS 609 Irving St., N. W.	
3. NAME OF DECEASED (Type or print) First Samuel Middle L. Last Cooper		4. DATE OF DEATH Month 5 Day 29 Year 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/6/1900
9. AGE (In years lost birthday) 66 yrs		10. IF UNDER 1 YEAR Months 6 Days 6 Hours 6 Min 6	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown - retired		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charlie Cooper		14. MOTHER'S MAIDEN NAME Mollie Taylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 042-18-1732	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma, left lung, with wide-spread metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary tuberculosis DUE TO (c) Pulmonary tuberculosis			INTERVAL BETWEEN ONSET AND DEATH 6 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (s) (this hospital) attended the deceased from 4/17/1967 , to 5/29/1967 , that (s) (we) last saw the deceased alive on 5/29/1967 , and that death occurred at 7:45P M , from causes and on the date stated above.			
22a. SIGNATURE <i>Moe Weiss</i>		22b. DATE SIGNED 5/29/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 6-2-67	23c. NAME OF CEMETERY OR CREMATORY HERMONY MEMORIAL LANDOVER MD.	23d. LOCATION (City or town) (County) (State)
24. FUNERAL DIRECTOR UNIVERSAL FUNERAL HOME 8164 ST NE.		25a. REC'D BY REGISTRAR DATE JUN 12 1967	
		25b. REGISTRAR'S SIGNATURE <i>John J. Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07064

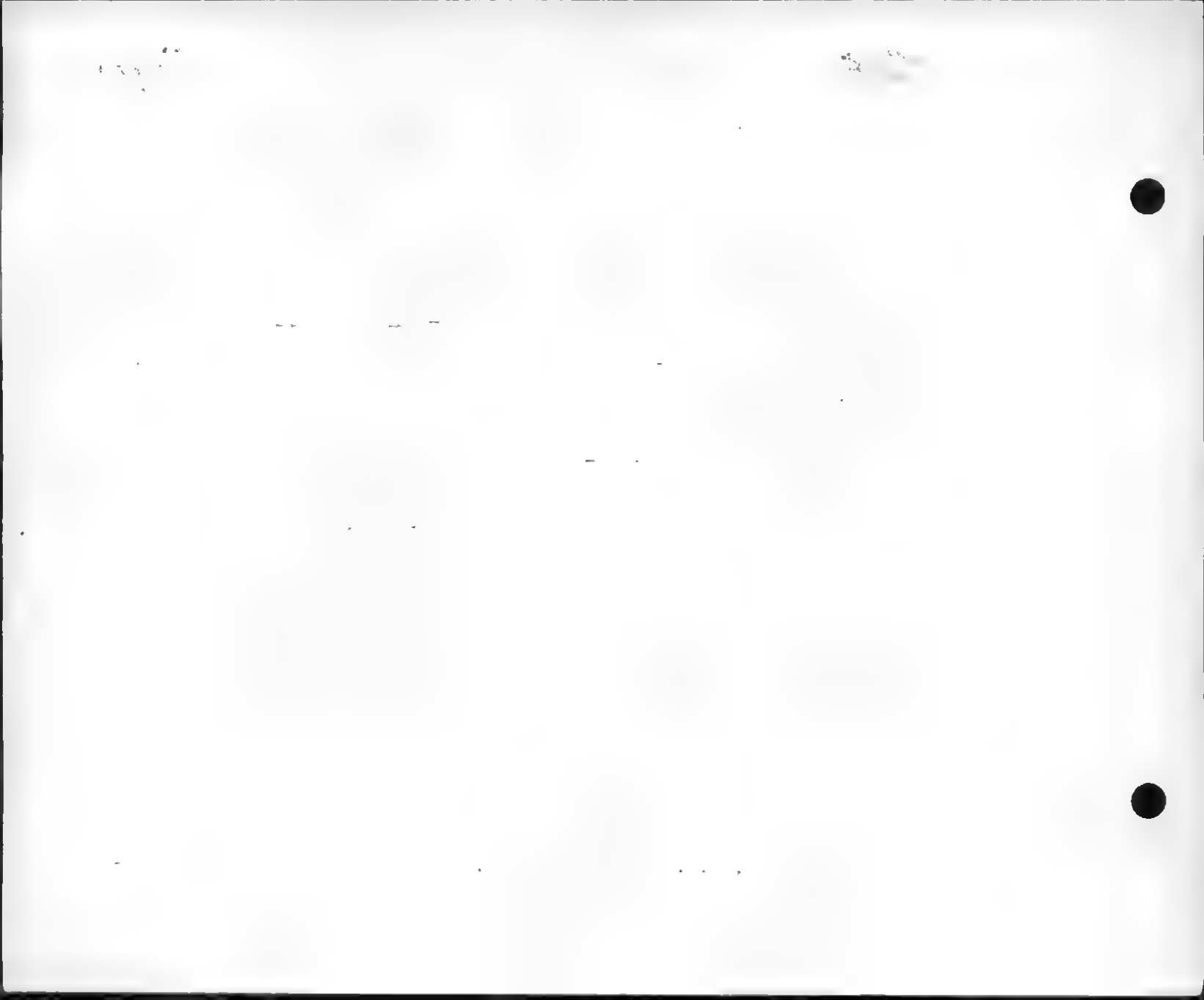
07045

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1055 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) Prince George General Hospital		e STREET ADDRESS 8218 Allendale Drive	
3 NAME OF DECEASED (Type or print) First Anthony Middle Louis Last Costantino		4. DATE OF DEATH Month 5 Day 5 Year 19 67	
5. SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1889 10-16-1891
9 AGE (In years last birthday) 75 77		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Barber		10b KIND OF BUSINESS OR INDUSTRY -	
11 BIRTHPLACE (State or foreign country) Italy		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Francis Costantino		14 MOTHER'S MAIDEN NAME Grace A. Coulatto	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 579-20-4544	
17 INFORMANT Mrs. Rose V. Costantino (above address)		Address (Wife) dress)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4:00 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH minutes over 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Indetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		22. DATE SIGNED 5-6-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city town or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 5/8/67	
23c NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d LOCATION (city or town) (County) (State) Colmar Manor, Md.	
24 FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a RECORD BY REGISTRAR Charles Judge DATE MAY 10 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07065

CERTIFICATE OF DEATH

07046

1. PLACE OF DEATH a. COUNTY PG. Riverdale, MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY PG.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Md.		c. LENGTH OF STAY IN 1b 2 Days.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Hospital,		d. STREET ADDRESS 6102 63rd Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Ethel M. Crawley		4. DATE OF DEATH Month Day Year May 1st 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-23-78
9. AGE (in years last birthday) 88 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife.		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? Amer.	
13. FATHER'S NAME Armiger, Mr. William.		14. MOTHER'S MAIDEN NAME Campbell, Mary ann.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 579 42 2999	
17. INFORMANT Eugene Leland Hospital, 4408 Queensbury Rd.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> DUE TO (b) <i>General arterio sclerosis</i> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2-3-1/2	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>20-9-67</i> , 1967, to <i>21-9-67</i> , that (I) (we) last saw the deceased alive on <i>20-9-67</i> , 1967, and that death occurred at <i>6:30</i> M, from causes and on the date stated above			
22a. SIGNATURE <i>W. M. M. M.</i>		22b. DATE SIGNED <i>5-1-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>H. M. M. M. M. D.</i>		22d. ADDRESS <i>Riverdale, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/5/67	
23c. NAME OF CEMETERY OR CREMATORY George Washington		23d. LOCATION (City or Town) (County) (State) Hyattsville P.G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE <i>MAY 5 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

MEDICAL CERTIFICATION

1977



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

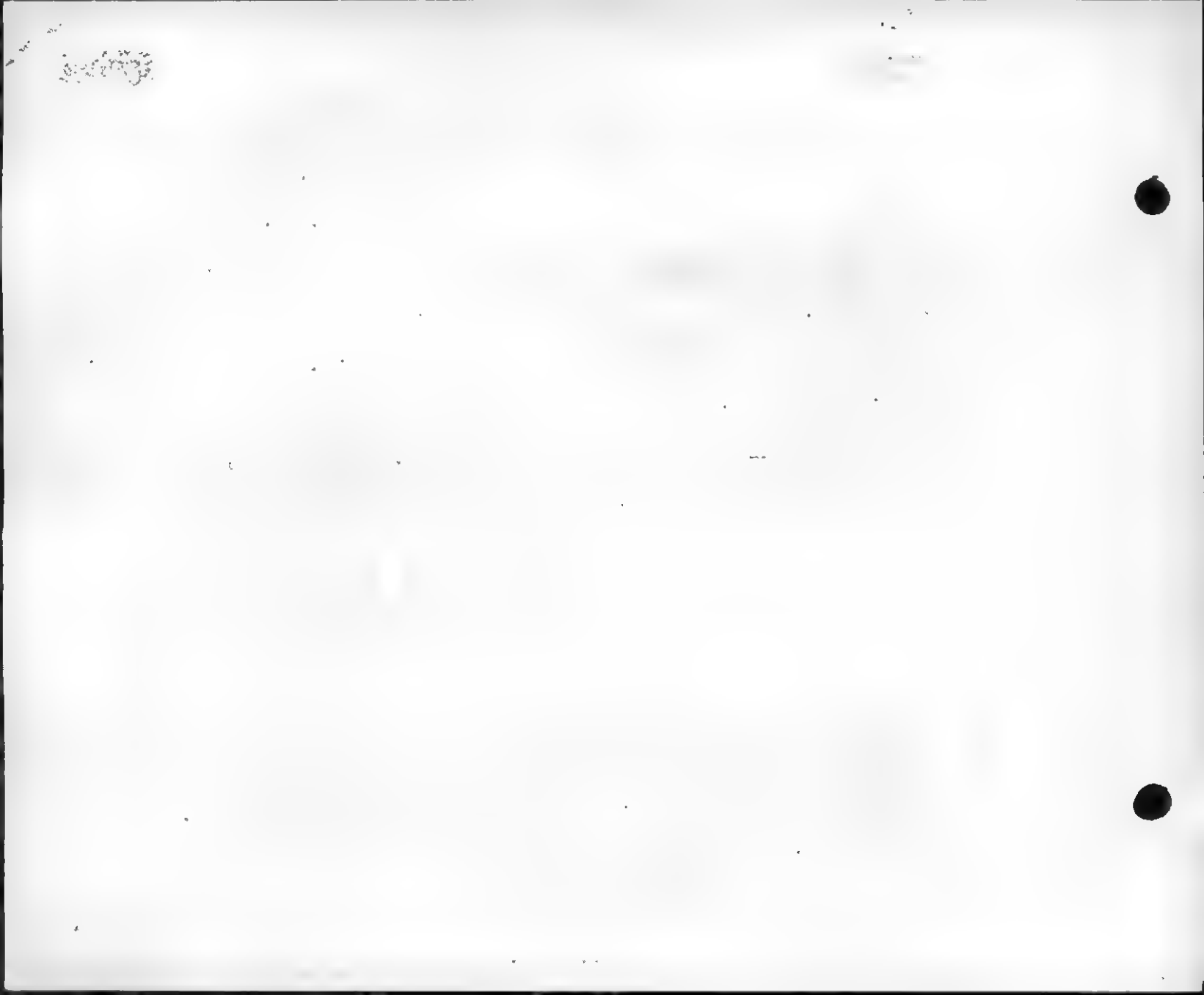
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07066

CERTIFICATE OF DEATH

07047

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt		c LENGTH OF STAY IN 1b 18 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greenbelt Convalescent Center		e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. 473	
f STREET ADDRESS 1263 Monroe St., N. E.		g IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Henrietta NMI Cunningham		4 DATE OF DEATH May 5, 1967 19 19	
5 SEX F.	6 COLOR OR RACE W.	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9/12/1877
9 AGE (In years last birthday) 89 yrs		10 IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min 1	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12 KIND OF BUSINESS OR IND. STRY Own Home	
13 BIRTHPLACE (County & State, or foreign country) Atkins, Ark.		14 CITIZEN OF WHAT COUNTRY? U.S.A.	
15 FATHER'S NAME Edward McBride Arnn		16 MOTHER'S MAIDEN NAME Martha Stepp	
17 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		18 SOCIAL SECURITY NO. 579-50-8548-A	
19 INFORMANT Edward P. Cunningham, Same as #2		Address	
19b CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCER OF PHARYNX 148X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 20 APRIL , 19 67 , to 5 MAY , 19 67 that (I) (we) last saw the deceased alive on 5 MAY , 19 67 , and that death occurred at 4:30 A.M. , from causes and on the date stated above.			
22a SIGNATURE Howard M. Tanning		22b DATE SIGNED MAY 5, 1967	
22c PHYSICIAN'S NAME (Type) Howard M. Tanning		22d ADDRESS Greenbelt, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	5/8/67	National Memorial Park	Falls Church, Va.
24 FUNERAL DIRECTOR Gawlers Funeral Home		25a REC'D BY REGISTRAR MAY 10 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			





MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07067

CERTIFICATE OF DEATH

07048

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN Hb 7 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Hghts. d. STREET ADDRESS 2341 Lyon Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Anna J. Daniels			4. DATE OF DEATH Month Day Year May 22, 1967				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/18/1900	9. AGE (in years last birthday) 66 yrs.	10. UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired telephone Operator		10b. KIND OF BUSINESS OR INDUSTRY Operator		11. BIRTHPLACE (County & State, or foreign country) Scotland			
13. FATHER'S NAME Neil Grant			14. MOTHER'S MAIDEN NAME Leonie ?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Neil Daniel, Son, Same As # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale 421.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Pulmonary emphysema DUE TO (c) Chronic bronchitis & emphysema					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (1) this hospital attended the deceased from 5/1/67 , 19 67 to 5/22 , 19 67 , that (1) was lost saw the deceased alive on 5/22 , 19 67 , and that death occurred at 1:55 p.m. from causes and on the date stated above							
22a. SIGNATURE 			22b. DATE SIGNED May 22, 1967		22c. PHYSICIAN'S NAME (Type) Leon R. Levitsky, M. D.		
22d. ADDRESS 3408 Rhode Island Ave. Mt. Rainier, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/25/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or town) (County) (State) Prince Georges, Maryland				
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland			25a. REC'D BY REGISTRAR MAY 24 1967	25b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10470

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07068

CERTIFICATE OF DEATH

07049

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE NORTH CAROLINA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AF BASE			c. LENGTH OF STAY IN 1b 2mo, 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GOLDSBORO		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS				d. STREET ADDRESS 628 FETCHET ST		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SALLY ANN DARNELL				4. DATE OF DEATH Month Day Year MAY 9 19 67			
5. SEX FEMALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 AUG 1931		9. AGE (In years last birthday) 35 yrs	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (County & State, or foreign country) MASS.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES FREDERICK DONOVAN				14. MOTHER'S MAIDEN NAME ISABEL FRANCES SEALE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO NA		16. SOCIAL SECURITY NO. 029-24-1186		17. INFORMANT Address HUSBAND SAME AS #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC & RESPERATORY FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) FAR ADVANCED CANCER OF BREAST WITH METASTASIS DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 3 March, 1967 , to 9 May, 1967 that (X) (we) last saw the deceased alive on 9 May 1967 , and that death occurred at 7:35 P.M. from causes and on the date stated above.							
22a. SIGNATURE <i>Dixon Yeste</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 9 May 67	
22c. PHYSICIAN'S NAME (Type) DIXON YESTE, CAPT, USAF MC				22d. ADDRESS USAF Hospital Andrews Andrews AFB, Wash DC 20331			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/13/67		23c. NAME OF CEMETERY OR CREMATORY MOUNTAIN VIEW CEMETERY		23d. LOCATION (City or Town) (County) (State) ROANOKE, VIRGINIA	
24. FUNERAL DIRECTOR ROBERT E. WILHELM ADDRESS 4308 SUITLAND ROAD, SUITLAND, MARYLAND				25a. REC'D BY REGISTRAR MAY 15 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

1000

1000

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07069

CERTIFICATE OF DEATH

07050

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Frederick	
c. LENGTH OF STAY IN Week		d. STREET ADDRESS Route #6- Frederick, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7121 Cabot Street		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ursula Middle B. Last Davis		4. DATE OF DEATH Month May Day 10 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1895
9. AGE (In years last birthday) 71 yrs		10. IF UNDER 1 YEAR Months 10 Days 19 Hours 67	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Elk Garden, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Patrick Henry Brown		14. MOTHER'S MAIDEN NAME Bridget Theresa Burke	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220 48 9519	
17. INFORMANT Mrs. Charles Watkins, Route #6, Frederick, Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lymphosarcoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 6 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic bronchitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 1964 to May 10, 1967 , that (I) (we) last saw the deceased alive on May 8, 1967 , and that death occurred at 1P M, from causes and on the date stated above.			
22a. SIGNATURE Henry V. Chase		22b. DATE SIGNED 5/11/67	
22c. PHYSICIAN'S NAME (Type) Henry V. Chase M.D.		22d. ADDRESS 804 Toll House Ave Frederick Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 13, 1967	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Frederick, Maryland
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR MAY 16 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2014-11-14
10:00 AM
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10:00 AM



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07070

CERTIFICATE OF DEATH

07051

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>				c. LENGTH OF STAY IN It			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Blue View Gardens</u>				d. STREET ADDRESS <u>Randle Cliffs, Chesapeake Beach</u>			
3. NAME OF DECEASED (Type or print) First <u>LYLA</u> Middle <u>PEARL</u> Last <u>DEAN</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>20</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22, 1891</u>		9. AGE (in years last birthday) <u>75</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Calvert County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Emory Gilburn</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Lyons</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>214-05-2947-T</u>		17. INFORMANT <u>Mrs. Hilda Friedler, Ches. Beach, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO <u>Massive Cerebrovascular Accident</u> DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>10 HRS.</u> <u>20 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u>					
20c. TIME OF INJURY Month Day Year <u>None</u>		20d. INJURY OCCURRED Where and how? <u>None</u>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bridge, etc.) <u>None</u>		20f. (City or town) (County) (State) <u>None</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>May 1, 1967</u> to <u>Present</u> , that (I) (we) last saw the deceased alive on <u>May 19, 1967</u> , and that death occurred at <u>1:30 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Arthur Shaver Jr.</u> M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED <u>5/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR. M.D.</u>				22d. ADDRESS <u>8808 OLD BRANCH AVE. CLINTON, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>May 22, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cremation Home</u>		23d. LOCATION (City or town) (County) (State) <u>Clinton Md.</u>	
24. FUNERAL DIRECTOR <u>Hutchins Funeral Home</u>		ADDRESS <u>Washington</u>		25a. REC'D BY REGISTRAR <u>MAY 25 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



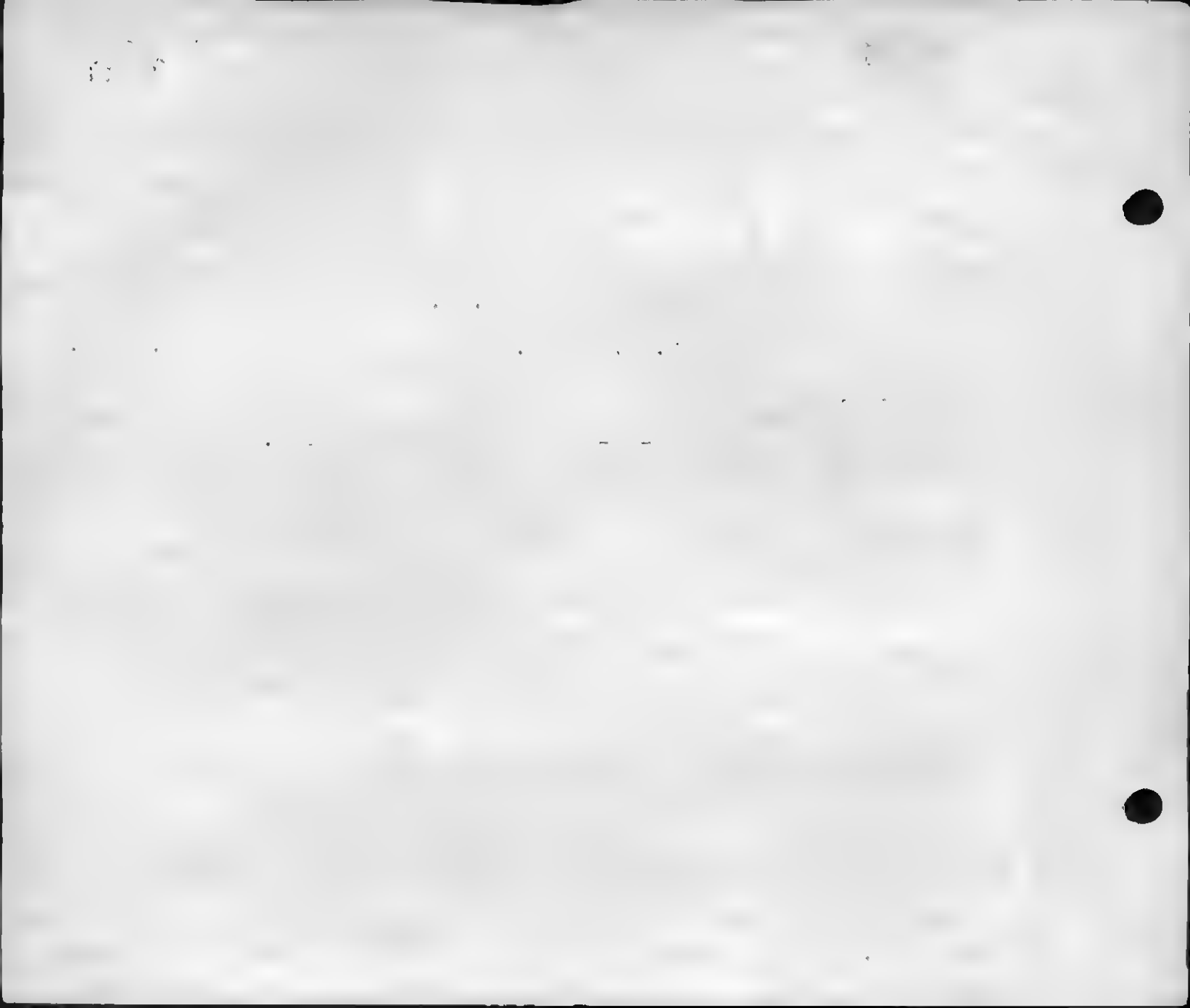
1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS 14
20M 5 63

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
07071 CERTIFICATE OF DEATH 07052

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Langley Park c. LENGTH OF STAY IN b. 1311 Merrimac Drive d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1311 Merrimac Drive		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Langley Park d. STREET ADDRESS 1311 Merrimac Drive	
3. NAME OF DECEASED (Type or print) Louis R DENNIS First Middle Last		4. DATE OF DEATH May 12 1967 Year Month Day	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1899 Yrs. 67
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney (retired)		9b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.	
10a. BIRTHPLACE (County & State, or foreign country) New York		10b. CITIZEN OF WHAT COUNTRY? U. S. A.	
11. FATHER'S NAME Louis R. Dennis		12. MOTHER'S MAIDEN NAME Rosa Lee Davenport	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) yes WWI		14. SOCIAL SECURITY NO. 578-54-2774	
15. INFORMANT Louis R. Dennis, Jr.		Address 6106 Madison St. East Riverdale Md.	
16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Rupture Aneurysme DUE TO subarachnoid hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Carcinoma DUE TO (c) pulmonary embolism PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec. 1966 to 5-12-1967, that (I) (we) last saw the deceased alive on 5-9-1967, and that death occurred at 8 A.M. from the causes and on the date stated above.			
22a. SIGNATURE [Signature] 22c. PHYSICIAN'S NAME (Type) OHANNES SAHAKYAN		22b. DATE SIGNED 22d. ADDRESS 6001 Landover Rd. Chevy Chase	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/16/67	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION (City, town or county) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE MAY 16 1967 Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.


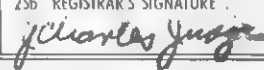
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07072

07053

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)			c. LENGTH OF STAY IN IS 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital				d. STREET ADDRESS 441 H St., N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Richard Middle J. Last Dickinson				4 DATE OF DEATH Month 5 Day 3 Year 19 67			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4/28/1905		9 AGE (In years lost birthday) 62 yrs	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Filling Sta. Attendant		10b. KIND OF BUSINESS OR INDUSTRY Gas Station		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard L. Dickinson				14. MOTHER'S MAIDEN NAME Lillie M. Payne			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 266-10-2115		17. INFORMANT Decedent Address _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive pulmonary hemorrhage DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) _____ (c) Pulmonary tuberculosis							INTERVAL BETWEEN ONSET AND DEATH 3 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Generalized arteriosclerosis with arteriosclerotic cardiovascular disease and peripheral vascular insufficiency.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that the (this hospital) attended the deceased from 4/21/ 19 67 , to 5/3/ 19 67 , that he (we) last saw the deceased alive on 5/3/ 19 67 , and that death occurred at 9:00M , from causes and on the date stated above							
22a. SIGNATURE  Moe Weiss, M. D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/3/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.				22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 7, 1967		23c. NAME OF CEMETERY OR CREMATORY Family Cemetery		23d. LOCATION (City or town) _____ (County) _____ (State) _____ Spotsylvania County Va.	
24. FUNERAL DIRECTOR F. Gasch's Sons ADDRESS Hyattsville, Md.				25a. REC'D BY REGISTRAR MAY 8 1967		25b. REGISTRAR'S SIGNATURE 	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07073

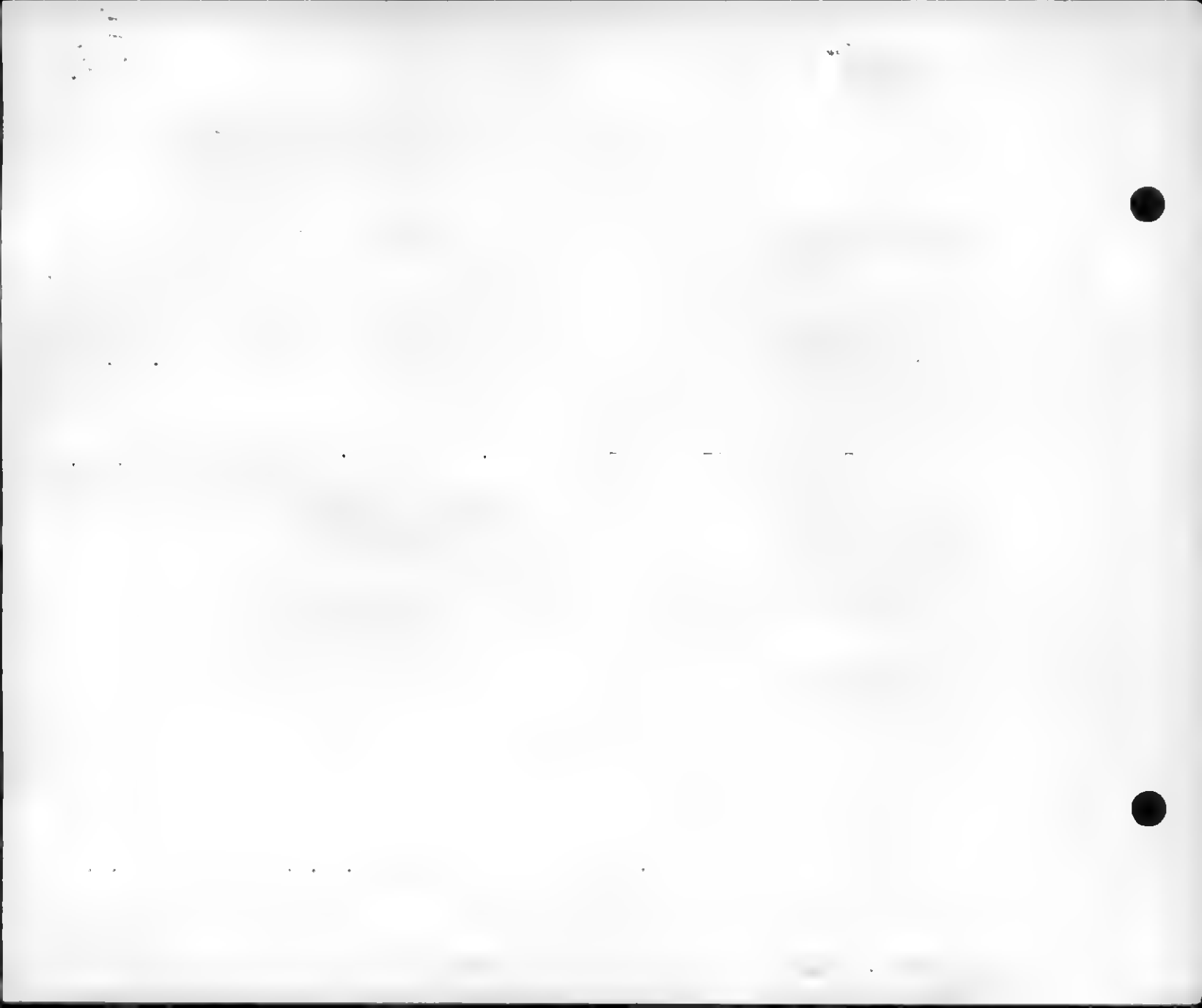
CERTIFICATE OF DEATH

07054

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN IT <u>30 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> d. STREET ADDRESS <u>4509 Oliver St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>ALBERICO</u> First <u>XXX</u> Middle Last <u>Di Paolo</u>				4. DATE OF DEATH Month <u>May</u> Day <u>10</u> Year <u>19 67</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/1/1904</u>		9. AGE (In years last birthday) <u>63</u> yrs		10. UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		11. UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operating Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Bernardo DiPaolo</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>036-16-2510</u>				17. INFORMANT <u>Mrs. Margaret E. DiPaolo</u>				<u>4509 Oliver St. Riverdale, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of the prostate</u> DUE TO (b) <u>Generalized metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>About 2 yrs</u>			
												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year <u> </u> Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , to <u>5-10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-9</u> , 19 <u>67</u> , and that death occurred at <u>2:15 AM</u> , from causes and on the date stated above.															
22a. SIGNATURE <u>Ottavio Gelmi</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>												22b. DATE SIGNED <u>May 10, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>Ottavio Gelmi, M. D.</u>												22d. ADDRESS <u>916 19th St., N.W. Washington, D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>5-13-1967</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>				23d. LOCATION (City or Town) (County) (State) <u>Frederick, Maryland</u>			
24. FUNERAL DIRECTOR <u>Robert E. Darter & Son</u> ADDRESS <u>Frederick, Maryland</u>												25a. REC'D BY REGISTRAR <u>MAY 15 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



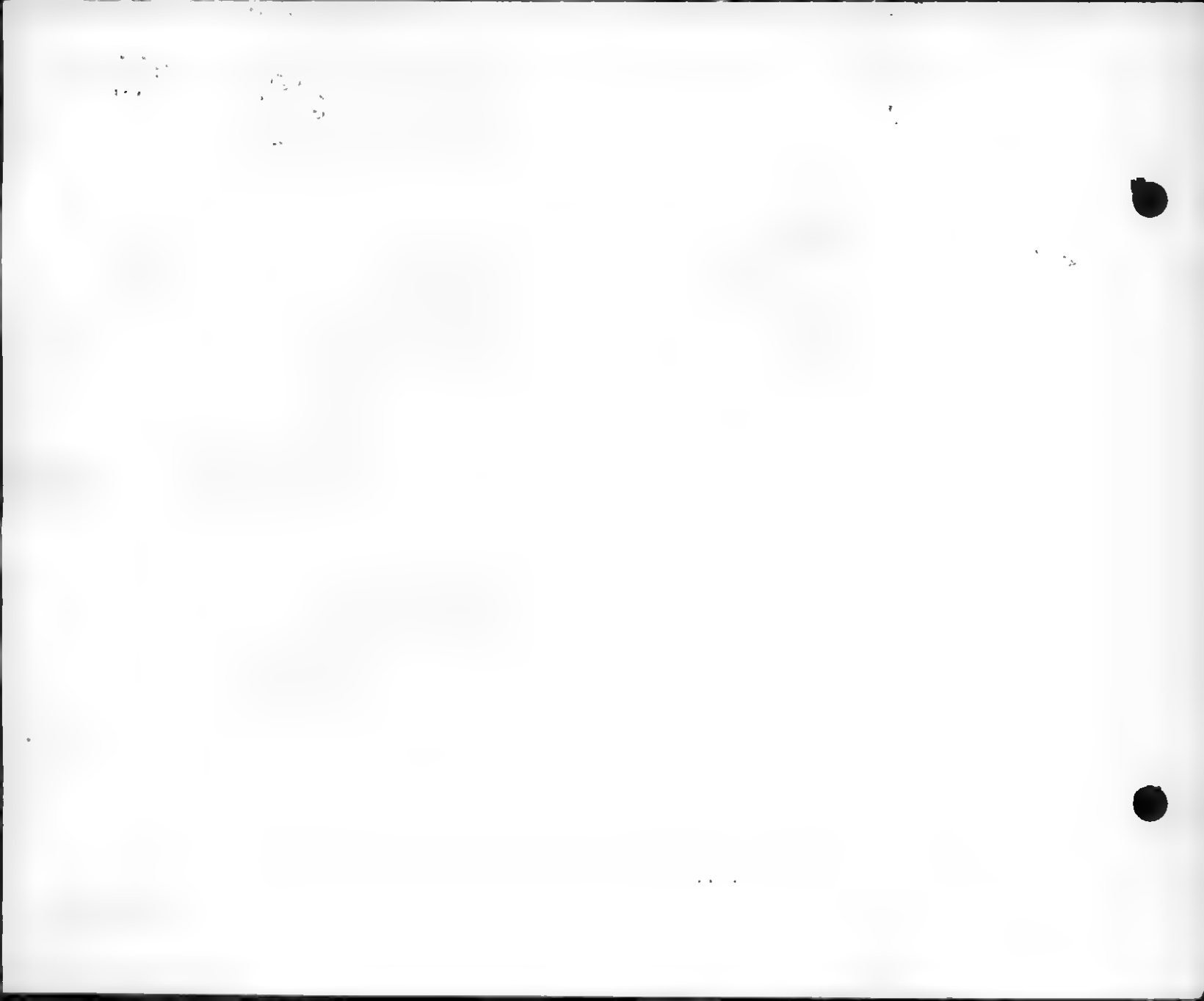
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if possible, delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #8, 11, 12, 13, 16 & 17 & 23c & 31 & 32 & 33 & 34 & 35 & 36 & 37 & 38 & 39 & 40 & 41 & 42 & 43 & 44 & 45 & 46 & 47 & 48 & 49 & 50 & 51 & 52 & 53 & 54 & 55 & 56 & 57 & 58 & 59 & 60 & 61 & 62 & 63 & 64 & 65 & 66 & 67 & 68 & 69 & 70 & 71 & 72 & 73 & 74 & 75 & 76 & 77 & 78 & 79 & 80 & 81 & 82 & 83 & 84 & 85 & 86 & 87 & 88 & 89 & 90 & 91 & 92 & 93 & 94 & 95 & 96 & 97 & 98 & 99 & 100

1 PLACE OF DEATH a COUNTY Prince George's b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c LENGTH OF STAY in 1b DOA d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's General Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a STATE Pennsylvania b COUNTY Philadelphia c CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) 7 d STREET ADDRESS 517 West York Street e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Bernice Dixon		4 DATE OF DEATH Month Day Year 5 27 19 67	
5. SEX female	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11/14/1914
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) N.C.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Robert Garrett		14 MOTHER'S MAIDEN NAME Dorothy Dixon	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT Lubie Dixon Rt. 2 Box 591 A Grifton, N.C.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain 5254 DUE TO (b) Compound skull fracture DUE TO (c) Trauma - auto accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Passenger in car involved in collision	
20c TIME OF INJURY Month, Day Year 3:15am 5-27 19 67		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home farm, factory, street, public bldg, etc.) Woodrow Wilson Bridge, Prince George's, Md.		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D. EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		22. DATE SIGNED 5-28-67	
23a BURIAL, CREMATION, REMOVAL (Specify) 5-29-67		23b DATE THEREOF	
23c NAME OF CEMETERY OR CREMATORY Ayden		23d LOCATION (City or town) (County) (State) Farmington, N.C.	
24 FUNERAL DIRECTOR Flayin 389 B.I. on Wash St		25a REC'D BY REGISTRAR JUN 1 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

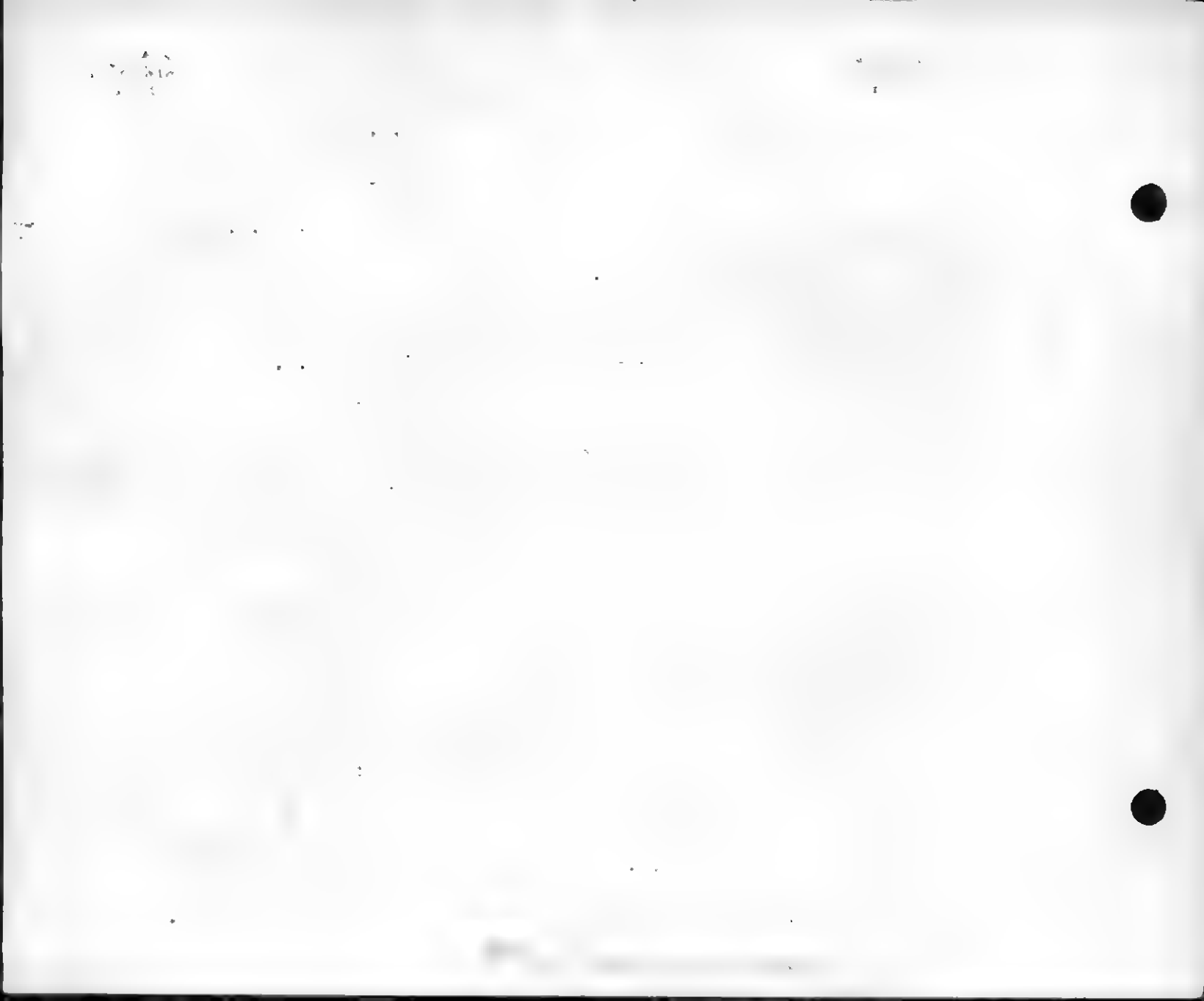
07075

CERTIFICATE OF DEATH

07056

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)			c. LENGTH OF STAY IN 1b 68 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital				d. STREET ADDRESS 2432 Irving St., S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edith Middle P. Last Dixon				4. DATE OF DEATH Month May Day 17 Year 19 67			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/22/1885	9. AGE (In years last birthday) 81 yrs	10. UNDER 1 YEAR Months Days Hours Min		11. UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (County & State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Frank Dade				14. MOTHER'S MAIDEN NAME Jane Ford			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No - - -		16. SOCIAL SECURITY NO 577-34-7271		17. INFORMANT Decedent Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic nephritis with uremia 4 days DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease with fibrillation DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis						INTERVAL BETWEEN ONSET AND DEATH 3 mo.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 'o m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 3/10 , 19 67 , to 5/17 , 19 67 , that (X) (we) last saw the deceased alive on 5/17/67 19 67 , and that death occurred at 10A M, from causes and on the date stated above.							
22a. SIGNATURE <i>Moe Weiss</i>				22b. DATE SIGNED 5/17/67		22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.	
22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 5-22-67		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Va.	
24. FUNERAL DIRECTOR <i>R. Hines Funeral Home</i>				25a. REGISTERAR MAY 19 1967		25b. REGISTERAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #11, 12, 13, 14, 17 & 23c Film #G339 6/12/67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07057

FOR STATE HEALTH DEPT

1 PLACE OF DEATH a COUNTY Prince George's b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c LENGTH OF STAY IN TB DOA d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a STATE Pennsylvania b COUNTY Philadelphia c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 759 d STREET ADDRESS 3418 Carlisle Street e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Laurine Dixon		4 DATE OF DEATH Month Day Year 5 27 19 67	
5 SEX female	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1-21-46
9 AGE (In years last birthday) 21		10 F UNDER 1 YEAR Months Days Hours Min 21	
11a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired)		11b KIND OF BUSINESS OR INDUSTRY	
12 BIRTHPLACE (State or foreign country) N.C.		13 CITIZEN OF WHAT COUNTRY? U.S.A.	
14 FATHER'S NAME Lutie Dixon		15 MOTHER'S MAIDEN NAME Olivia Dixon	
16 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		17 SOCIAL SECURITY NO	
18 INFORMANT Lutie Dixon Rt. 1, 5014 Grifton, N.C.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laceration of Brain 5254 DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Multiple occipital skull fractures DUE TO (c) Trauma - auto accident			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Passenger in car involved in collision	
21 TIME OF INJURY Month Day Year Hour a.m. p.m. 3:15 a.m. 5-27 19 67		22 INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work Woodrow Wilson Bridge, Prince George's, Md.	
23 PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		24 (City or town) (County) (State) Prince George's, Md.	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Not a cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		22. DATE SIGNED 5-28-67	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF 5-29-67	
23c NAME OF METERY OR REMATORY Avden		23d LOCATION (City or town) (County) (State) Avden, N.C.	
24 FUNERAL DIRECTOR Progen 389 B.I. on NW Wash. St.		25 REGISTRAR'S SIGNATURE Charles Judge	
25 REGISTRAR'S SIGNATURE		26 REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07077

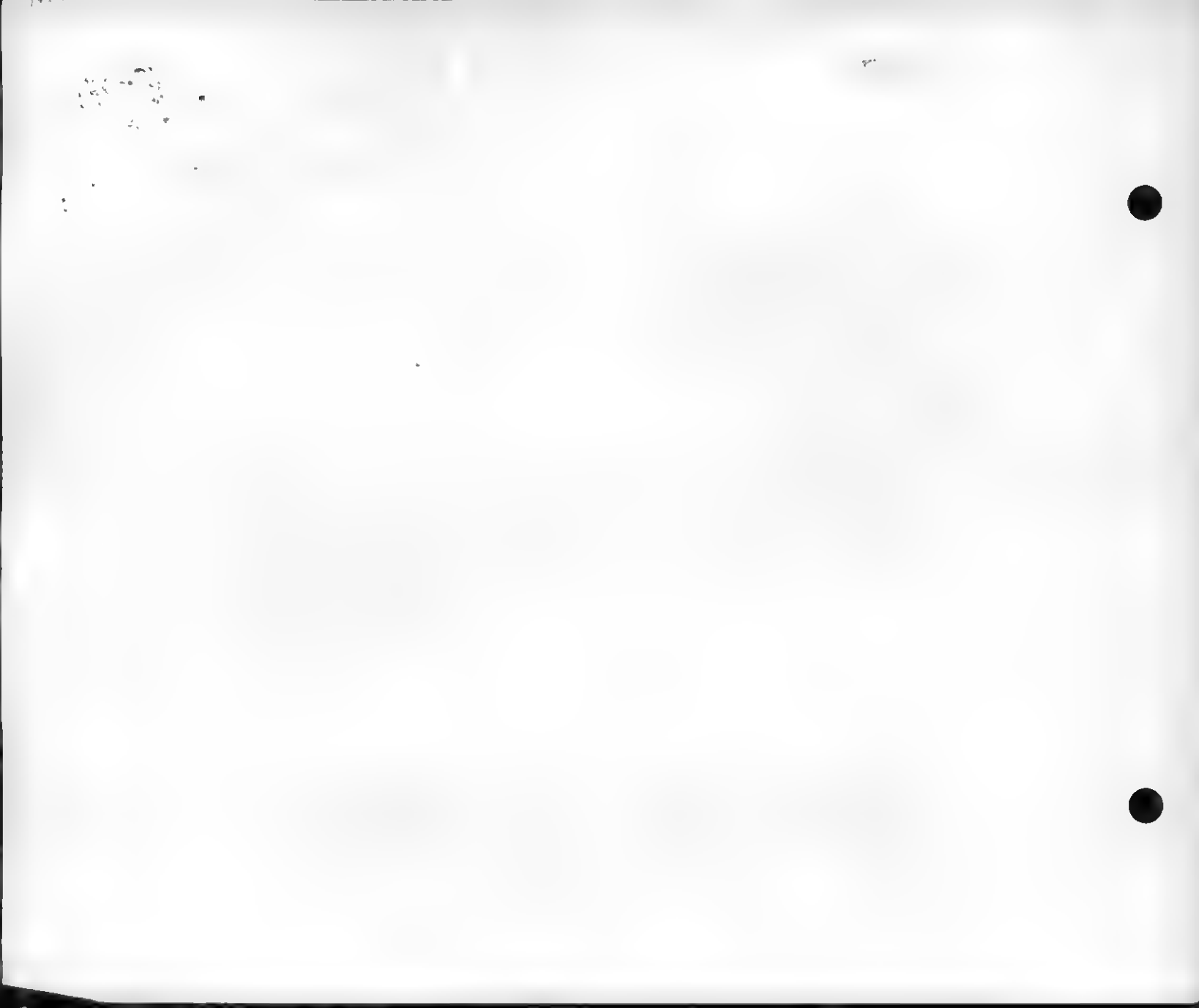
CERTIFICATE OF DEATH

07058

1 PLACE OF DEATH a COUNTY <u>Pr. Georges</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Md.</u> b COUNTY <u>Pr. Geo.</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c LENGTH OF STAY IN 1b			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George Hosnital</u>				e STREET ADDRESS <u>7003-A St. SE.</u>			
3 NAME OF DECEASED (Type or print) First <u>Audrey</u> Middle <u>C</u> Last <u>Dodson</u>				4 DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1967</u>			
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Oct. 28, 1911</u>	9 AGE (In years lost birthday) yrs <u>55</u>	10 UNDER 1 YEAR Months <u>55</u> Days	11 IF UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>D. C.</u>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <u>Edward Magner</u>				14 MOTHER'S MAIDEN NAME <u>Annie Russell</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16 SOCIAL SECURITY NO. (If yes give war or dates of service)		17 INFORMANT <u>Martha Baker</u> Address <u>(daughter)</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Systolic shock</u> <u>260 X</u> DUE TO (b) <u>Infected stump of thigh amputation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>Peripheral vascular gangrene</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>72 hrs</u> <u>59 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus, Myocardial fibrosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>3/23/67</u> , 19 <u>67</u> , to <u>5/21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/20</u> , 19 <u>67</u> , and that death occurred at <u>M</u> , from causes and on the date stated above							
22a SIGNATURE <u>John H. Bayly</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS					
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>5/24/67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d LOCATION (City or Town) (County) (State) <u>Suitland. Md</u>	
24 FUNERAL DIRECTOR <u>Lee Funeral Home</u>		ADDRESS <u>Washington, D.</u>		25a REC'D BY REGISTRAR <u>MAY 24 1967</u>		25b REGISTRAR'S SIGNATURE <u>Michaela Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07078

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07059

1 PLACE OF DEATH a COUNTY <u>Prince George's</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Prince George's</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c LENGTH OF STAY IN 1b <u>16 1/2</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6703 Goodluck Road</u>		e STREET ADDRESS <u>6703 Goodluck Road</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Murgatroyd Dolbey</u>		4 DATE OF DEATH Month Day Year <u>5 7 19 67</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>21 June 1884</u>
9 AGE (In years last birthday) <u>82</u>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TOOL MAKER</u>	
10b KIND OF BUSINESS OR INDUSTRY <u>ERCO CORP</u>		11. BIRTHPLACE (State or foreign country) <u>ENGLAND</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>UNKNOWN</u>	
14 MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>N</u>	
16. SOCIAL SECURITY NO <u>579-03-2124</u>		17 INFORMANT <u>MRS. WALTER MARTIN</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>4200</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>over 3 mo.</u>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>5-8-67</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b DATE THEREOF <u>MAY 11 1967</u>	
23c NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>		23d LOCATION (City or Town) (County) (State) <u>BLADENBURG MD</u>	
24 FUNERAL DIRECTOR <u>W.W. Chambers Co. Riverdale, Md.</u>		25a REC'D BY REGISTRAR DATE <u>MAY 15 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE
HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death if any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

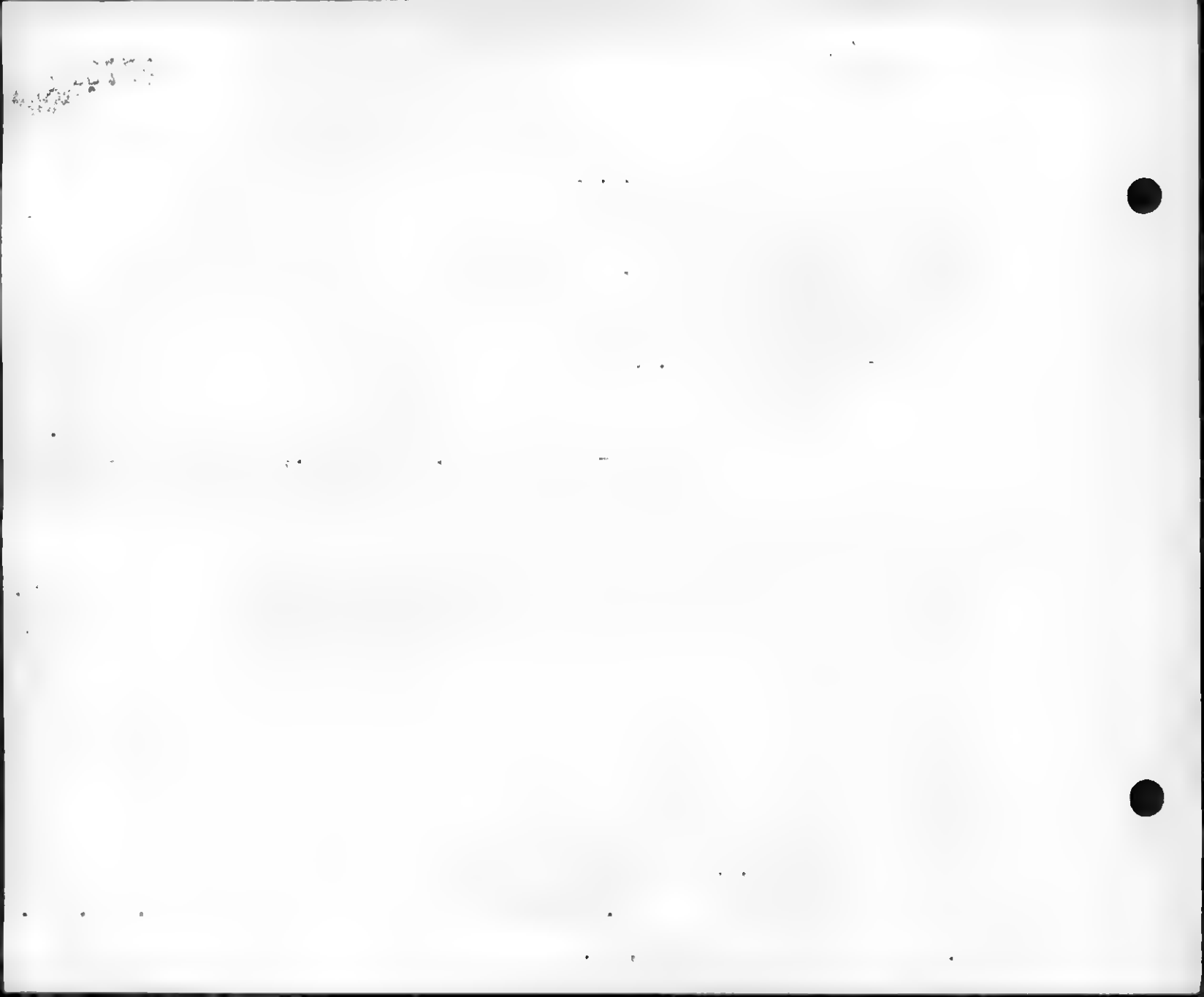
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07073

07060

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if not full-time residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN b. D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital				d. STREET ADDRESS 2801 Nicholson Street			
3 NAME OF DECEASED (Type or print) First Lorin Middle H. Last Drennan				4. DATE OF DEATH Month May Day 5 Year 19 67			
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 29 May 1903	9 AGE (In years last birthday) 63 yrs	10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Electro type			10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.		11 BIRTHPLACE (State or foreign country) Ohio		12 CITIZEN OF WHAT COUNTRY? Yes
13 FATHER'S NAME Unknown			14 MOTHER'S MAIDEN NAME Unknown				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16 SOCIAL SECURITY NO. 375-01-2503		17 INFORMANT Lorin H. Drennon Jr., 11805 Milbern Drive		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive hemorrhage 5/5/67 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Oesophageal varices DUE TO (c) Cirrhosis of liver							INTERVAL BETWEEN ONSET AND DEATH minutes unknown over 5 yrs.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe			CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
			Address (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE THEREOF 8 May 1967		23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d LOCATION (City or Town) (County) (State) Colmar Manor Pr. Geo. Md.
24 FUNERAL DIRECTOR F. Gasch & Sons, Hyattsville, Md.			ADDRESS		25a REC'D BY REG STRAR MAY 8 1967		25b REG STRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

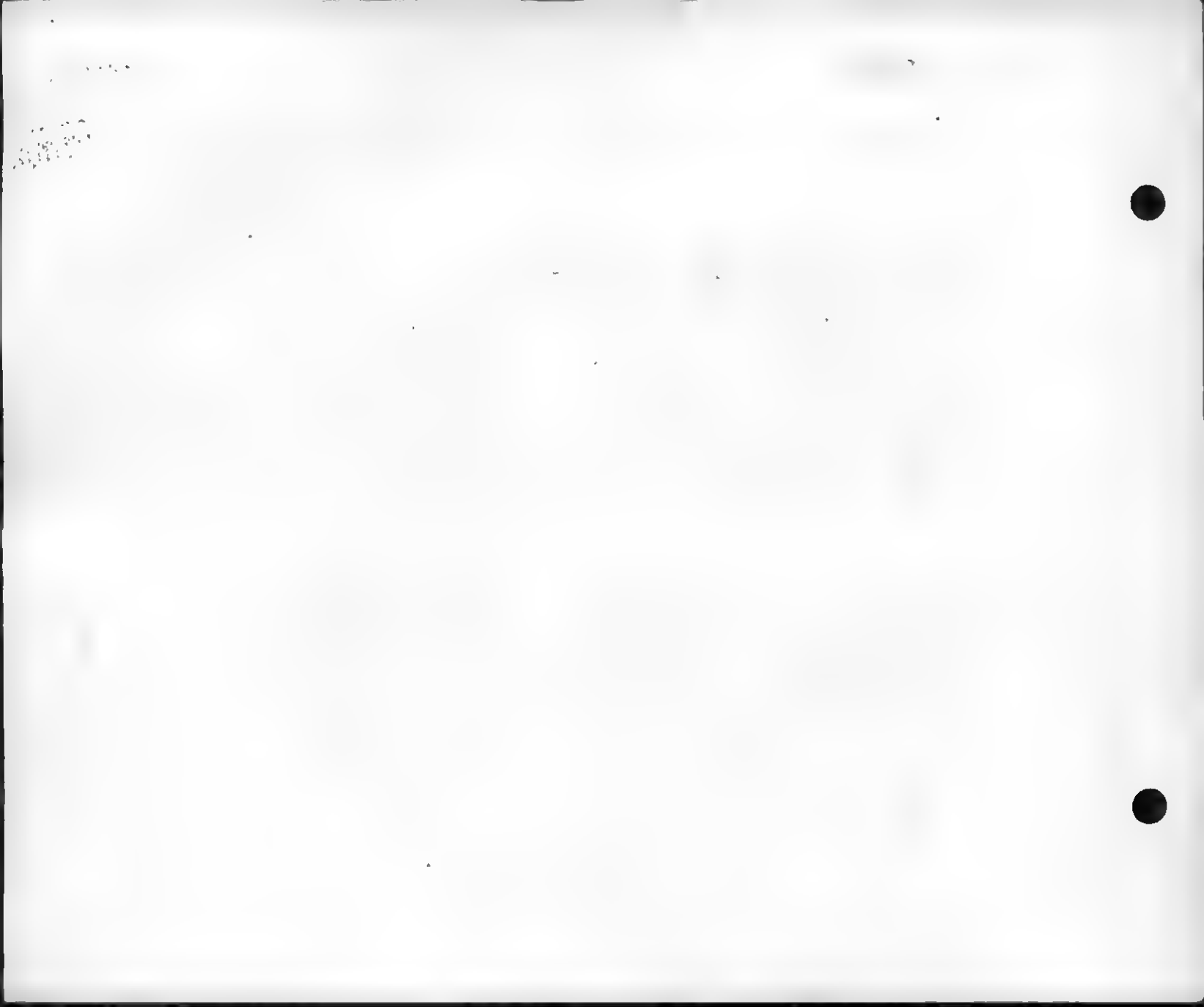
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07080

CERTIFICATE OF DEATH

07061

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE = Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 31 minutes	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 6152 Springhill Ter., Apt. 303	
3. NAME OF DECEASED (Type or print) First Middle Last ERIK ALEXIS Emerson		4. DATE OF DEATH Month Day Year May 18 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1967
9. AGE (In years last birthday) 1 yrs		10. IF UNDER 1 YEAR Months Days Hours Min 18 19 67 31	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Hospital	
11. BIRTHPLACE (County & State, or foreign country) Cheverly Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Capers Emerson		14. MOTHER'S MAIDEN NAME Joan Louise Mitchell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. None	
17. INFORMANT James Capers Emerson		Address 6152 Spring Hill Terrace Greenbelt Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ATELECTASIS NEONATORUM - DILAT 7000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 hr.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the physician) attended the deceased from May 18, 1967 to May 18, 1967 , that (I) (we) last saw the deceased alive on May 18, 1967 , and that death occurred at 3:30 PM , from causes and on the date stated above			
22a. SIGNATURE Louis H. Moody, Jr., M.D.		22b. DATE SIGNED 5-20-67	
22c. PHYSICIAN'S NAME (Type) Louis H. Moody, Jr., M.D.		22d. ADDRESS Prof. Bldg., Greenbelt, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 23, 1967	23c. NAME OF CEMETERY OR CREMATORY Washington National	23d. LOCATION (City or Town) (County) (State) Suitland Maryland
24. FUNERAL DIRECTOR W.W. Chambers Silver Spring Md.		25a. REC'D BY REGISTRAR MAY 25 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



1-3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07081		07062	
1. PLACE OF DEATH a. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Greenbelt		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mt Ranier	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greenbelt Convalescent Center		d. STREET ADDRESS 3406 Newton St. Apt. 3	
3. NAME OF DECEASED (Type or print) First Middle Last Bessie Louise Engel		4. DATE OF DEATH Month Day Year May 10 1967	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH Oct. 16, 1891	
9. AGE (In years last birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (County & State, or foreign country) D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William L. Snow		14. MOTHER'S MAIDEN NAME Anna C. Burriss	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Evelyn Greene		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Carcinoma of the lung DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 months 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-12, 1964, to 5-10, 1967, that (I) (we) last saw the deceased alive on 5-8, 1967, and that death occurred at 12 PM, from the causes and on the date stated above.			
22a. SIGNATURE Donald C. Edgren		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DONALD C. EDGREN		22d. ADDRESS 3500 East-West Highway Baltimore, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-13-67	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION (City, town or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR Lee Funeral Home. Washington, D. C.		25a. REC'D BY REGISTRAR MAY 15 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07082

CERTIFICATE OF DEATH

07063

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE Maryland b. COUNTY Prince George	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c LENGTH OF STAY IN 1b College Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Madison Manor Nursing Home		d STREET ADDRESS 5815 Swarthmore Drive	
3 NAME OF DECEASED (Type or print) Rachel (NMN) Evans		4 DATE OF DEATH Month May Day 30, Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 27, 1870
9 AGE (in years last birthday) 97 yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY Hospital	
11. BIRTHPLACE (County & State or foreign country) England		12 CIT ZEN OF WHAT COUNTRY England	
13 FATHER'S NAME James Wescott Smith		14 MOTHER'S MAIDEN NAME Rebecca ?	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 220 4671062	
17 INFORMANT Mrs. Barbara Marx		Address Same as #2	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 GENERALIZED ARTERIO SCLEROSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 20 YRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS A TOLPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)	
20c TIME OF DEATH Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from MAR. 13, 1967 to MAY 30, 1967, that (I) (we) last saw the deceased alive on MAY 30, 1967, and that death occurred at 11:35 PM, from causes and on the date stated above.			
22a SIGNATURE J. E. Bowman		22b. DATE SIGNED MAY 31, 1967	
22c. PHYSICIAN'S NAME (Type) J. E. BOWMAN, M.D.		22d. ADDRESS 4621-18TH ST., N.E.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 6/1/67	23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln	23d LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.
24 FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JUN 5 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

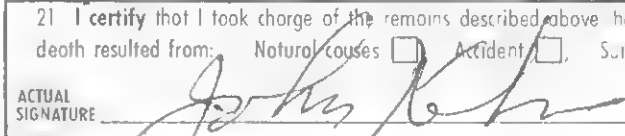

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07083

07064

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate m'ts, write RURAL and give nearest town) Bowie		c. LENGTH OF STAY in lb minutes		c. CITY OR TOWN (If outside corporate m'ts, write RURAL and give nearest town) Bowie		16.1	
d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) Penna R.R. Tracks, Zug Rd.				d. STREET ADDRESS 12010 Maycheck Lane		17. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marie Middle B. Last Everett				4. DATE OF DEATH Month 5 Day 3 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-19-1924		9. AGE (In years lost birthday) 42 yrs	10. FUNERAL 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME-MAKER		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME ROY S. BRIDGES SR.				14. MOTHER'S MAIDEN NAME CALLIE E. BRIDGES			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv'ce) No.		16. SOCIAL SECURITY NO		17. INFORMANT (husband) BENJAMIN L. EVERETT		Address Lane, Bowie, Md. 12010 MAYCHECK	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Total injuries DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II. of item 18.) Struck by Railroad train.					
20c. TIME OF INJURY Month Day Year Hour : min 5:17pm 5-3- 19 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Penna. R.R. Tracks, Zug Rd., Bowie, Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						22. DATE SIGNED 5-4-67	
ACTUAL SIGNATURE 		EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street, city, town, or county) Riverdale, Md.		23. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 5/6/1967		23. NAME OF CEMETERY OR CREMATORY National Memorial Park Falls Church Virginia		23d. LOCATION City or Town (County) (State)	
24. FUNERAL DIRECTOR Hysong's Funeral Home		Address 1300 N. St., N.W.		25d. REC'D BY REGISTRAR MAY 8 1967		25b. REGISTRAR'S SIGNATURE 	

2/1/1

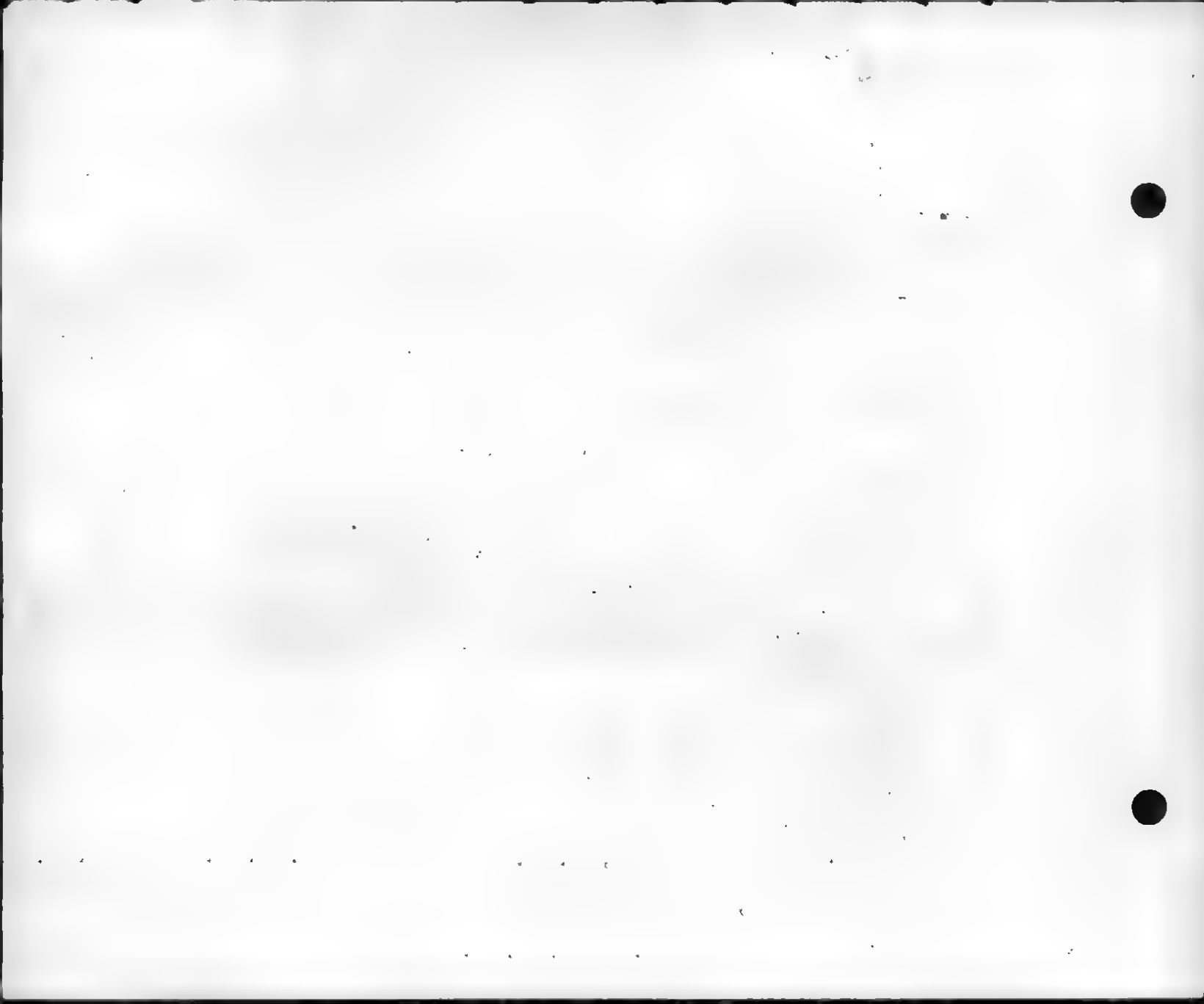
2/1/1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
07084 08560											
1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL</u> c. LENGTH OF STAY IN 1b <u>9 Mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>12405 DELORAIN CIR.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL - WASHINGTON, DC - 161</u> d. STREET ADDRESS <u>12405 DELORAIN CIR</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>THOMAS</u> First <u>FRANCIS</u> Middle <u>FEENEY</u> Last 4. DATE OF DEATH <u>MAY</u> Month <u>31</u> Day <u>19</u> Year <u>67</u>						5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>JAN. 23 1904</u> 9. AGE (in years last birthday) <u>63</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>POLICEMAN</u> 11. BIRTHPLACE (County & State, or foreign country) <u>NEW YORK</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>						13. FATHER'S NAME <u>THOMAS F. FEENEY</u> 14. MOTHER'S MAIDEN NAME <u>ELIZABETH DOHERTY</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>061-20-2658</u> 17. INFORMANT <u>AGNES FEENEY-WIFE ABOVE</u> Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>612-X</u> DUE TO <u>Chronic Pyelo-nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prostatic Inflammation</u> (c) <u>Diabetes Mellitus & Proliferated Sanguine</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus & Proliferated Sanguine</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> 19 <u>63</u> to <u>May -31</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 28</u> 19 <u>67</u> , and that death occurred at <u>8:50</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>E. Stuart Lyddand</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>May 31 1967</u>											
22c. PHYSICIAN'S NAME (Type) <u>E. Stuart Lyddand, M. D.</u> 22d. ADDRESS <u>3066 Quæ St. N. W. Wash, D. C.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>June 1, 1967</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Sts Peter & Paul Cem</u> 23d. LOCATION (City, town or county) (State) <u>Elmira, New York</u>											
24. FUNERAL DIRECTOR <u>Joseph Gallers Son's Inc. Wash, D. C.</u> ADDRESS <u>Wash, D. C.</u> 25a. REC'D BY REGISTRAR <u>JUN 7 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate writing the words "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07085

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07065

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE Maryland b COUNTY Prince George's			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c LENGTH OF STAY IN 1b DOA			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last Forrest F. Ferguson				4 DATE OF DEATH Month Day Year 5 22 1967			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6 April 1940	9 AGE (In years last birthday) 27 y's	10 UNDER 1 YEAR Months Days		11 UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SOLDIER			10b KIND OF BUSINESS OR INDUSTRY U.S. ARMY		11 BIRTHPLACE (State or foreign country) NEW JERSEY		12 CITIZEN OF WHAT COUNTRY? U.S.
13 FATHER'S NAME JOHN F. FERGUSON				14 MOTHER'S MAIDEN NAME LAURA JACOBS			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES ACTIVE		16 SOCIAL SECURITY NO 153-30-6418		17 INFORMANT DIANA FERGUSON		Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carbon monoxide intoxication 8910 DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Inhaled carbon monoxide in garage at home.					
20c TIME OF INJURY Month, Day Year hour a.m. or p.m. 3:00pm 5-22-1967		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Garage		20f CITY OR TOWN (County) (State) Hyattsville, Md.	
				20g STREET ADDRESS 3909 Nicholson St.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Indetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe				22. DATE SIGNED 5-23-67			
EXAMINER'S NAME (Type) John Kehoe, M.D.				Address (Street city town, or county) Riverdale, Md.			
23a BURIAL CREMATION REMOVAL (Specify)		23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or town) (County) (State)	
BURIAL		5-29-1967		ARLINGTON NATIONAL CEM		ARLINGTON, VIRGINIA	
24 FUNERAL DIRECTOR W.W. CHAMBERS CO. RIVERDALE, MD.				25a REC'D BY REGISTRAR MAY 26 1967		25b REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07086

07066

1 PLACE OF DEATH a. COUNTY Prince George's Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges' Hospital		d. STREET ADDRESS 8500 N. Hampshire Ave.	
3 NAME OF DECEASED (Type or print) HARRY FINKELSTEIN		4 DATE OF DEATH Month May Day 9 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 26, 1898
9. AGE (In years lost birthday) 68 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RESTAURANT OWNER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MAX FINKELSTEIN		14. MOTHER'S MAIDEN NAME JENNIE ----	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Wife		Address 8500 N. Hampshire Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis, acute 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Arteriosclerotic Hypertensive Heart Dis. (c) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 4 yrs 4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Oct 10, 1966 , to May 8, 1967 , that (I) (we) last saw the deceased alive on May 8, 1967 , and that death occurred at 10:20 AM , from causes and on the date stated above			
22a. SIGNATURE Isidore Shulman		22b. DATE SIGNED 5-10-67	
22c. PHYSICIAN'S NAME (Type) ISIDORE SHULMAN		22d. ADDRESS 915-19th St NW DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/12/67	
23c. NAME OF CEMETERY OR CREMATORY Old Montefiore Cem.		23d. LOCATION (City or Town) (County) (State) Queens, Long Island, N.Y.	
24. FUNERAL DIRECTOR Bernard Danzansky & Sons		25a. REC'D BY REGISTRAR St. NW, Wash. DC	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE MAY 15 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
- Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07087

CERTIFICATE OF DEATH

07067

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3-1/2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt		16.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 45 D Ridge Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) XXXX (Last) Middle (First) Finkelstein, - Morris		DATE OF DEATH Month Day Year May 19, 1967					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/15/90	9. AGE (In years last birthday) 77 yrs	10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (County & State, or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 062-05-7436A		17. INFORMANT Address 45-D Ridge Rd. Esther Gerson, Daughter Greenbelt, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral vascular hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 days yell.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 1957 to May 19, 1967, that (I) (we) last saw the deceased alive on May 19, 1967, and that death occurred at 12:10M, from causes and on the date stated above							
22a. SIGNATURE [Signature]				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. PM DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-19-67	
22c. PHYSICIAN'S NAME (Type) William C. Weintraub, M. D.				22d. ADDRESS Prof. Bldg. Greenbelt, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-21-67		23c. NAME OF CEMETERY OR CREMATORY Natl. Mem. Park		23d. LOCATION (City or Town) (County) (State) Falls Church, Va.	
24. FUNERAL DIRECTOR Goldberg Funeral Home				ADDRESS 4217-9th St. N.W.		25a. REC'D BY REGISTRAR MAY 23 1967	
						25b. REGISTRAR'S SIGNATURE [Signature]	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

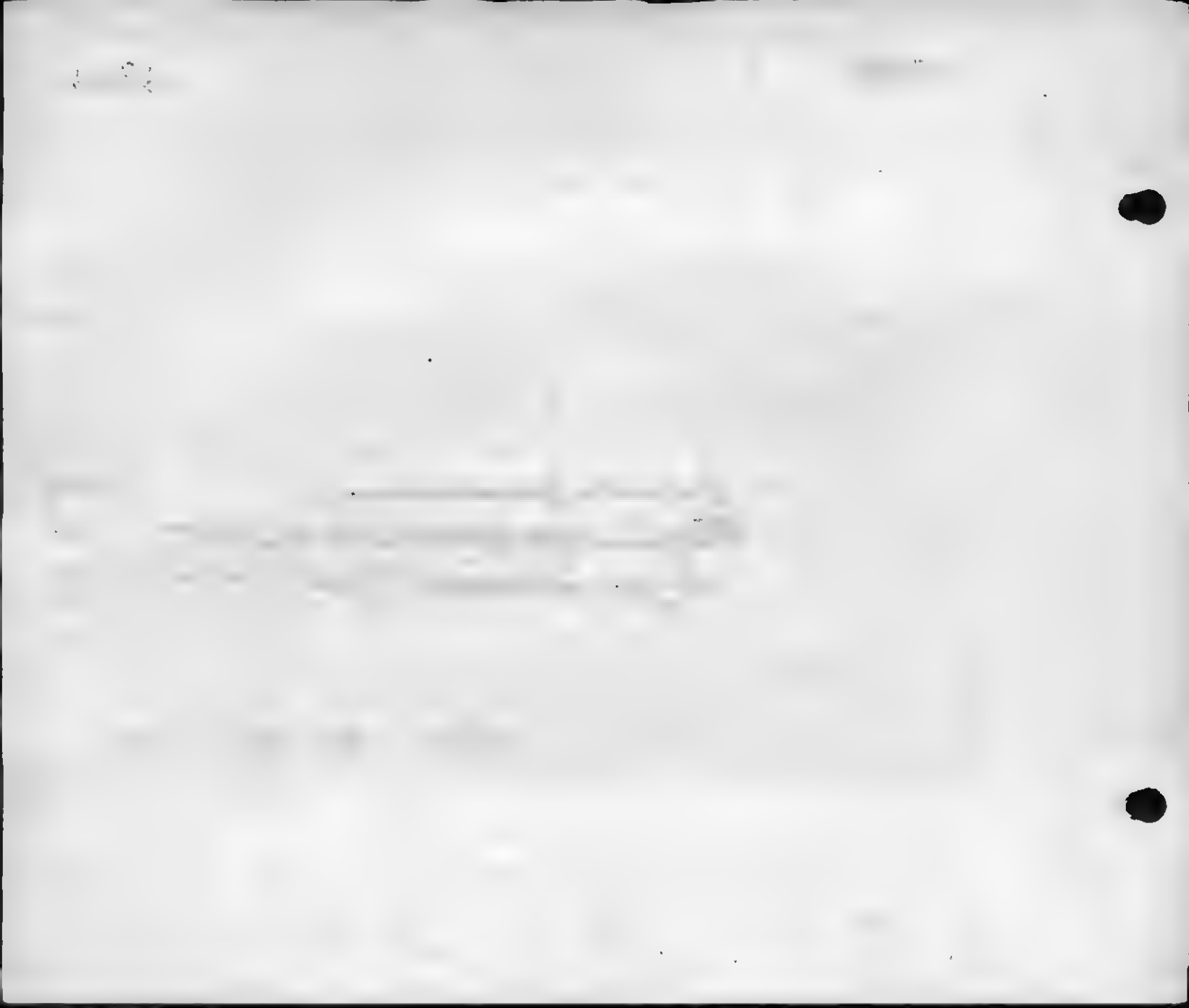
CERTIFICATE OF DEATH

07088

07068

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>P.G.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> LENGTH OF STAY IN TB				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>109 2nd St</u>				d. STREET ADDRESS <u>109 2nd St</u>			
3. NAME OF DECEASED (Type or print) <u>Frances Paula Fisher</u>				4. DATE OF DEATH <u>May 2 1967</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 28 1889</u> 78 yrs.	
9. AGE (In years last birthday) <u>78</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Laurel Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>James Federline</u>			
14. MOTHER'S MAIDEN NAME <u>Frances Shipley</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>31X</u>				17. INFORMANT <u>J.M. Fisher, Laurel Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>bronchopneumonia</u> DUE TO <u>31X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic accident</u> DUE TO <u>hypertension + quad-G.S.</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a.m.</u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/29</u> 19 <u>47</u> to <u>5/2</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/2</u> 19 <u>67</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>J.M. Warren</u> M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>J.M. Warren</u>				22d. ADDRESS <u>Laurel Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<u>Burial</u>		<u>5-5-67</u>		<u>Trinity Hill Cem</u>		<u>Laurel Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Donaldson</u> ADDRESS <u>Laurel Md</u>				25. REC'D BY REGISTRAR <u>MAY 9 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

07083

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07069

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a. STATE Maryland b. COUNTY Howard ✓			
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Riverdale				c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Laurel			
c. LENGTH OF STAY IN 1b DOA				d. STREET ADDRESS RFD 1, Box 297			
a. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First McLure Middle Lawrence Last Fisher				4. DATE OF DEATH Month 5 Day 3 Year 1967			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 22 April 1905	9. AGE (In years lost birthday) 62 yrs	IF UNDER 1 YEAR Months 6 Days 3 Hours 19 Min 67		IF UNDER 24 HRS Hours 19 Min 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) electrician		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wesley Fisher				14. MOTHER'S MAIDEN NAME Mary Rasmussen			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 1-10-67		17. INFORMANT Grace Fisher Address Gumbort Rd Laurel Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) due to (c) due to							INTERVAL BETWEEN ONSET AND DEATH minutes unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D.				22. DATE SIGNED 5-4-67			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, OR REMOVAL (Specify)		23b. DATE THEREOF 5-6-67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem		23d. LOCATION (City or town) (County) (State) Glen Burnie Md.	
24. FUNERAL DIRECTOR W. W. Sanders Address Laurel Md				25. RECEIVED BY REGISTRAR MAY 8 1967		26. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
3
A STATE HEALTH DEPT.

1

MARYLAND STATE DEPARTMENT OF HEALTH

Item #2c Film #G4831/12/67 pc
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07090

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07070

1. PLACE OF DEATH a. COUNTY Prince George's MARY. AND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN TB DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover Laurel	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 104 Woodlawn Ct.		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Henry Thomas Florentine				4. DATE OF DEATH Month Day Year 5 2 19 67			
5. SEX male		6. CO. OR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-22-1897	
9. AGE (In years lost birthday) 70		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. US. OCCUPATION (Give kind of work done during most of working life, even if retired) Transportation				10b. KIND OF BUSINESS OR INDUSTRY Self Emp.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Henry Florentine				14. MOTHER'S MAIDEN NAME Mary Christina Lombardo			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) yes 8-1918/12-1918				16. SOCIAL SECURITY NO 213-20-9975		17. INFORMANT Mrs Mary E. Florentine, Temonium, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes - over 2 months						INTERVAL BETWEEN ONSET AND DEATH minutes unknown	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME Type: John Kehoe, M.D. Riverdale, Md.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city town or county)			
22. DATE SIGNED 5-3-67							
23a. BURIAL, CREMATION, OR OTHER DISPOSAL BURIAL		23b. DATE THEREOF May 5, 1967		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEM.		23d. LOCATION (City or Town, County, State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR Harold S. Wade, Laurel, Maryland				25a. REGISTRATION MAY 5 1967 DATE			

Charles Judge

20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

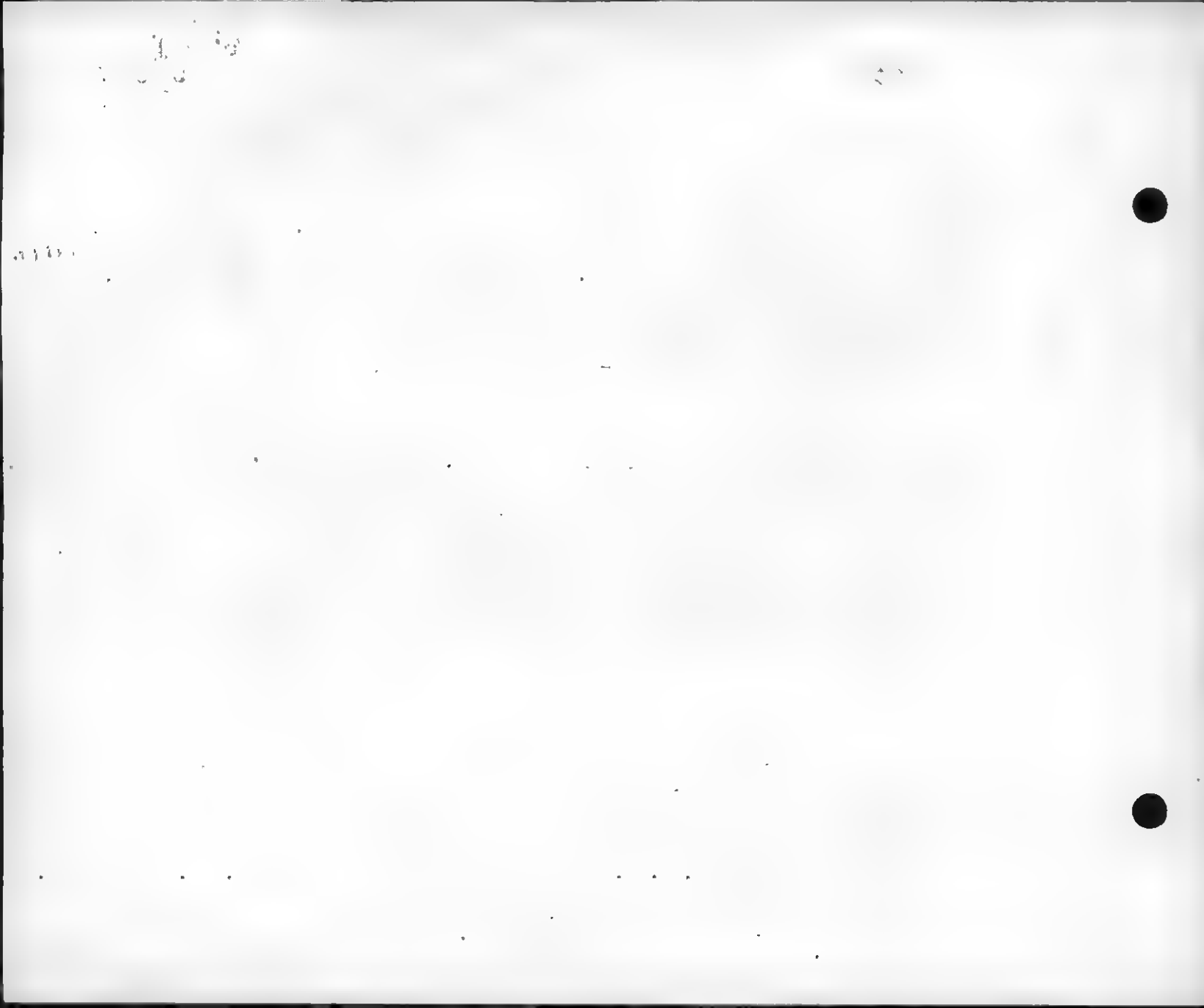
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07091

CERTIFICATE OF DEATH

07071

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY in 1b 19 Hours			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 6802 - 23rd Ave.			
3. NAME OF DECEASED (Type or print) First Middle Last Maud F. Fort				4. DATE OF DEATH Month Day Year May 24, 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/8/89	9. AGE (in years lost birthday) 77 yrs	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS Hours Min.	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Wash., D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry T. Roland				14. MOTHER'S MAIDEN NAME Frances S. Cameron			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 213-50-6238		17. INFORMANT Mrs. Norma V. Niles - Crownsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO (b) Psychoneurosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Asphyxia						INTERVAL BETWEEN ONSET AND DEATH 2 days 3 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1960 , 19____, to May 24, 19 67 , that (I) (we) last saw the deceased alive on May 24, 1967 , and that death occurred at 3:10 P.M. from causes and on the date stated above.							
22a. SIGNATURE Leon Levitsky M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Leon Levitsky, M. D.				22d. ADDRESS 3408 Rhode Island Ave., Mt. Rainier, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/26/67		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION (City or town) (County) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR Halley's Funeral Home Inc.				25a. REC'D BY REGISTRAR MAY 29 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

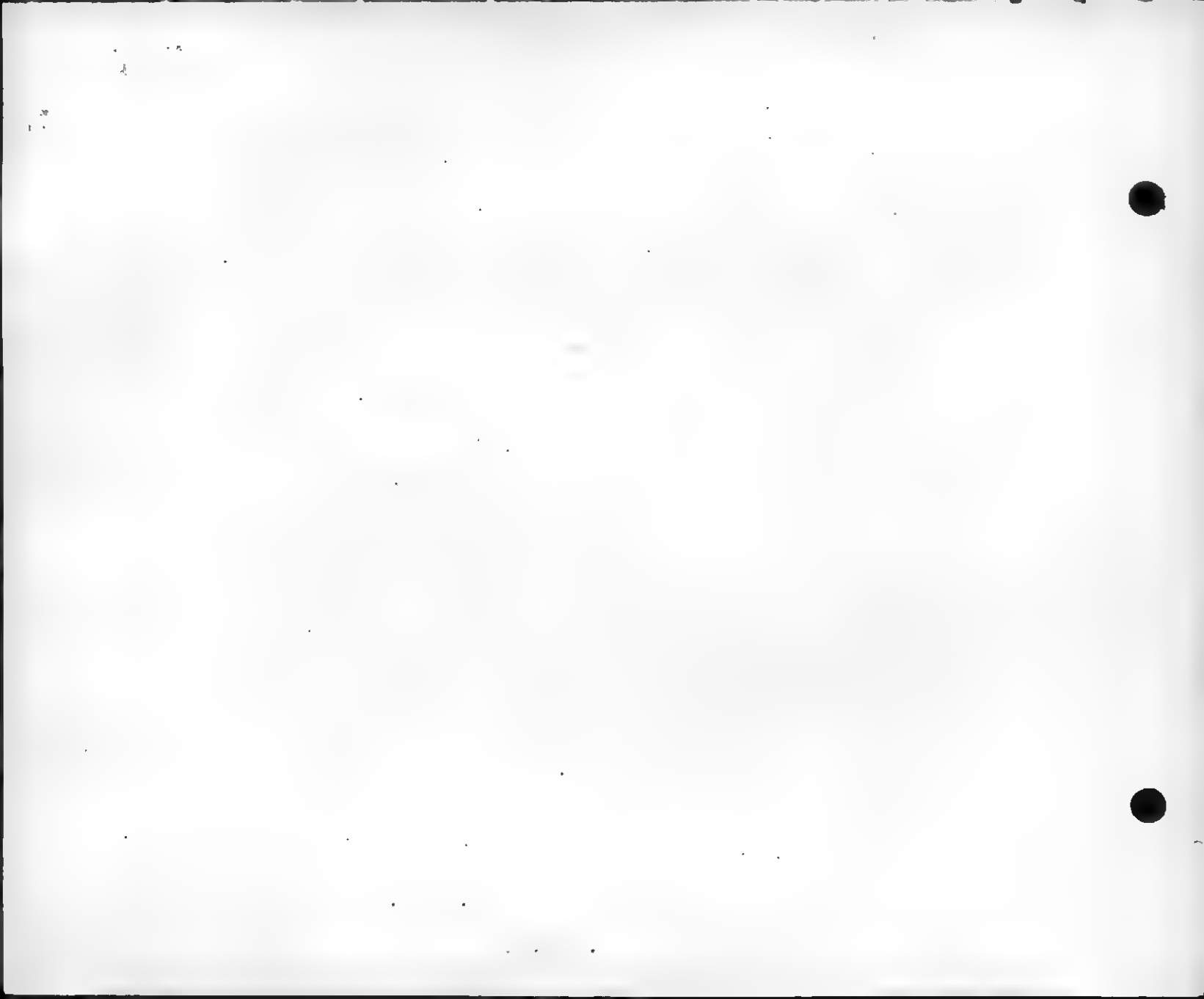


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>07092</p> </div> <div> <p>1</p> <p>07072</p> </div> </div> <div style="text-align: center;"> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div>											
<p>1. PLACE OF DEATH</p> <p>a. COUNTY PRINCE GEORGES MARYLAND</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANDREWS AFB</p> <p>c. LENGTH OF STAY IN 1b 5 Days</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) USAF HOSPITAL ANDREWS AFB</p>						<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE MARYLAND b. COUNTY PRINCE GEORGES</p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FORRESTVILLE</p> <p>d. STREET ADDRESS 8303 Beltz Drive</p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>					
<p>3. NAME OF DECEASED (Type or print)</p> <p>First EDWARD H. Middle GALPERN Last </p>						<p>4. DATE OF DEATH</p> <p>Month MAY Day 7 Year 1967</p>					
<p>5. SEX MALE</p>		<p>6. COLOR OR RACE CAJ</p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH 17 Jun 1918</p>		<p>9. AGE (in years last birthday) 48 yrs.</p>		<p>IF UNDER 1 YEAR Months Days Hours Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USARMY</p>				<p>10b. KIND OF BUSINESS OR INDUSTRY USARMY</p>		<p>11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA</p>		<p>12. CITIZEN OF WHAT COUNTRY? USA</p>			
<p>13. FATHER'S NAME ISRAEL GALPERN</p>						<p>14. MOTHER'S MAIDEN NAME GOLDIA ABRAMSON</p>					
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service)</p>				<p>16. SOCIAL SECURITY NO. 159-01-8356</p>		<p>17. INFORMANT WIFE</p>		<p>Address SAME AS #2</p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) Cardiac Arrest</p> <p>4201 DUE TO (b) HEART FAILURE & ACUTE PULMONARY EDEMA</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) MYOCARDIAL INFARCTION</p>										<p>INTERVAL BETWEEN ONSET AND DEATH 1 HR</p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>											
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>							
<p>20c. TIME OF INJURY Month, Day, Year</p> <p>Hour a.m. 19 p.m. </p>				<p>20d. INJURY OCCURRED</p> <p>While <input type="checkbox"/> Not While <input type="checkbox"/></p> <p>at work <input type="checkbox"/> at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>			
<p>21. I certify that (this hospital) attended the deceased from 2 May, 1967, to 7 May, 1967, that (he) last saw the deceased alive on 7 May, 1967 and that death occurred at 6:15 PM from the causes and on the date stated above.</p>											
<p>22a. SIGNATURE Richard J. Wisely</p>						<p>22b. DATE SIGNED May 11</p>		<p>22c. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/></p>			
<p>22c. PHYSICIAN'S NAME (Type) RICHARD J. WISELY, CAPT, USAF MC</p>						<p>22d. ADDRESS USAF Hospital Andrews Andrews AFB Wash DC 20333</p>					
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>				<p>23b. DATE THEREOF 5/11/67</p>		<p>23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.</p>		<p>23d. LOCATION (City, town or county) (State) Arlington, Virginia</p>			
<p>24. FUNERAL DIRECTOR Bernard Danzansky & Sons St. Wash. DC</p>						<p>25a. REC'D BY REGISTRAR MAY 11 1967</p>		<p>25b. REGISTRAR'S SIGNATURE Charles Judge</p>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

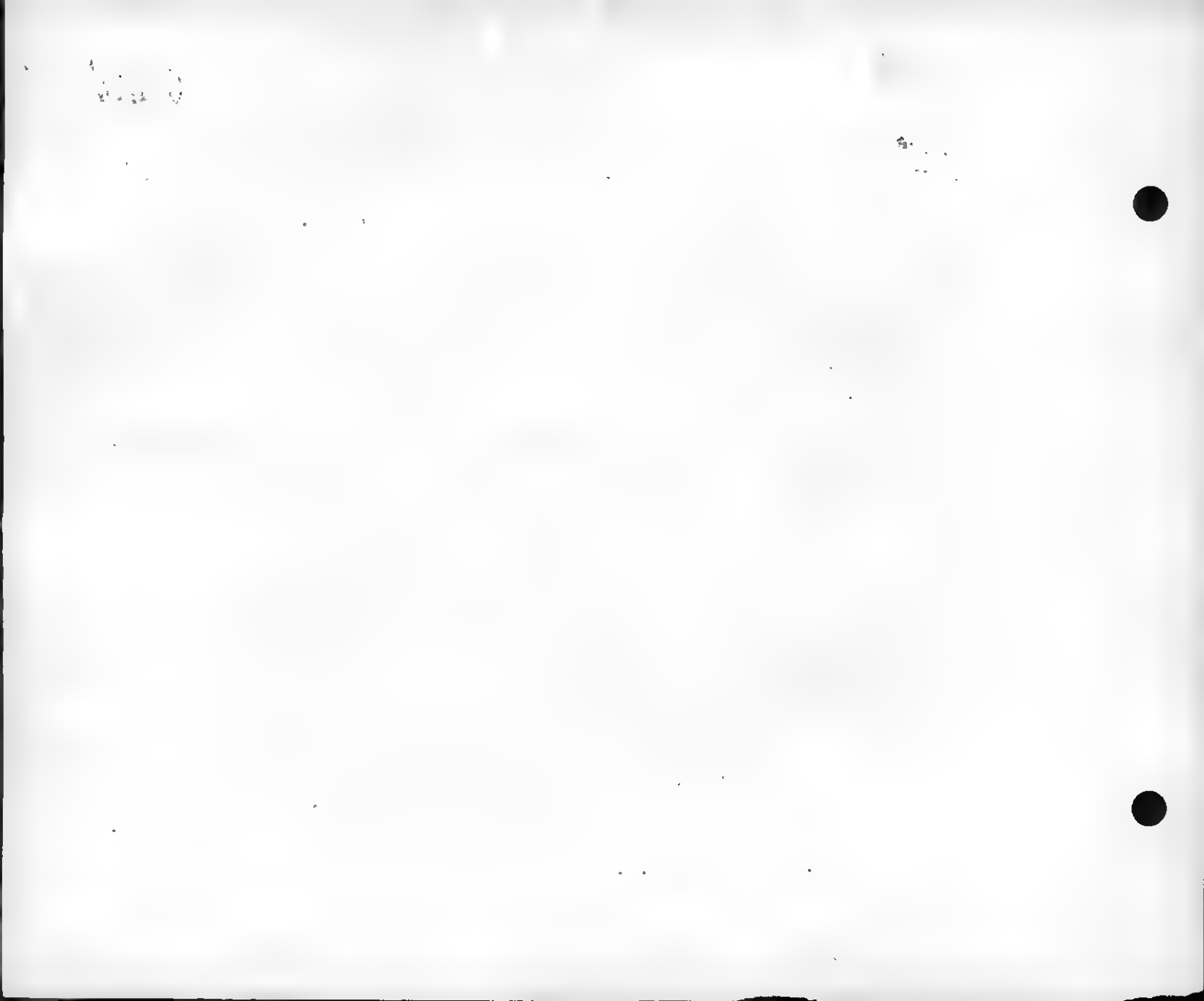
07093

CERTIFICATE OF DEATH

07073

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 31 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 4110 Warner Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Samuel Gandler				4. DATE OF DEATH Month Day Year May 8, 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/15/1895		9. AGE (In years last birthday) 71 yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578-10-8488A		17. INFORMANT MRS. ESTHER GANDLER		Address 4110 WARNER AVE. HYATTSTVILLE, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiovascular shock 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute myocardial Infarction DUE TO (c) Severe Arteriosclerotic Cardiovascular Disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from April 7, 19 67 , to May 8, 19 67 , that (X) (we) last saw the deceased alive on May 8, 19 67 , and that death occurred at 9:50 AM from causes and on the date stated above.							
22a. SIGNATURE U. Hernandez				22b. DATE SIGNED May 8, 1967		22c. PHYSICIAN'S NAME (Type) U. Hernandez, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5-10-67		23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery	
24. FUNERAL DIRECTOR Donald M. Stein				25a. REC'D BY REGISTRAR MAY 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	
23d. LOCATION (City or Town) (County) (State) Hyattsville, Prince Geo. Md.				23e. ADDRESS 232 Carroll St.			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07094

CERTIFICATE OF DEATH

07074

1 PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Release of information) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORRESTVILLE		c. LENGTH OF STAY IN lb 39 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) REGENT NURSING HOME		d. STREET ADDRESS 5114 Valley Road	
3 NAME OF DECEASED (Type or print) First DOROTHEA Middle E. Last GARDELLA		4. DATE OF DEATH Month MAY Day 8 Year 1967	
5 SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/10/1901
9. AGE (In years last birthday) 66 yrs		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min 1	
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY X	
11. BIRTHPLACE (County & State or foreign country) N. Y.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME John A. Sheil		14. MOTHER'S MAIDEN NAME Harriet J. Wands	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Helen R. Morris		Address 5114 Valley Road S. E.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4x00 DUE TO Congestive Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Dis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Emphysema		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1960 to 1967 , that (I) (we) last saw the deceased alive on 7-7-1967 , and that death occurred at 10:17 M, from causes and on the date stated above.			
22a. SIGNATURE Bernard Katzman		22b. DATE SIGNED 5-8-67	
22c. PHYSICIAN'S NAME (Type) BERNARD KATZMAN M.D.		22d. ADDRESS 2645 Weyler Rd. S.E. Wash. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-10-1967	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Virginia	
24. FUNERAL DIRECTOR Robert E. Wilkins		25a. REC'D BY REGISTRAR MAY 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S NAME Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1944

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

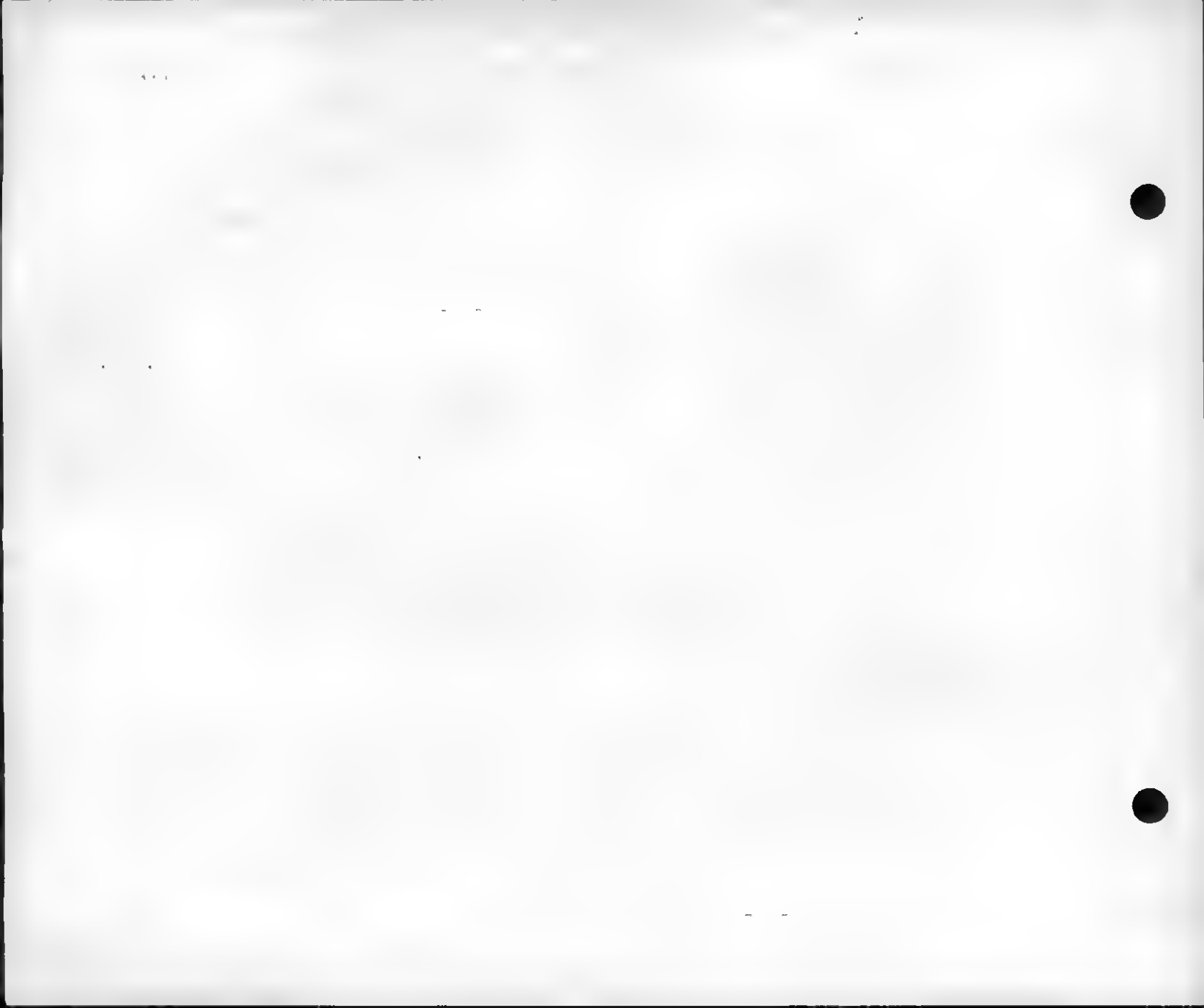
07095

CERTIFICATE OF DEATH

07075

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant				c. LENGTH OF STAY IN b Seat Pleasant			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7830 Valley Park Road				d. STREET ADDRESS 7830 Valley Park Road			
3. NAME OF DECEASED (Type or print) MARION V GATES First Middle Last				4. DATE OF DEATH Month May Day 7 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-27-1890	9. AGE (In years last birthday) 77 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Raymond Finley				14. MOTHER'S MAIDEN NAME Loretta Burke			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT Address Sheila G. Shaffer 7830 Valley Park Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) (c)						INTERVAL BETWEEN ONSET AND DEATH 16 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/20 , 19 65 , to 5/7 , 19 67 , that (I) (we) last saw the deceased alive on 4/22 , 19 67 , and that death occurred at 8:30 PM , from causes and on the date stated above.							
22a. SIGNATURE Charles Jones, M.D. M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-10-67		23c. NAME OF CEMETERY OR CREMATORY Great Neck Cemetery		23d. LOCATION (City or Town) (County) (State) Onset Massachusetts	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home		ADDRESS 308 Suitland Suitland Maryland		25a. REC'D BY REGISTRAR MAY 11 1967		25b. REGISTRAR'S SIGNATURE Charles Jones	

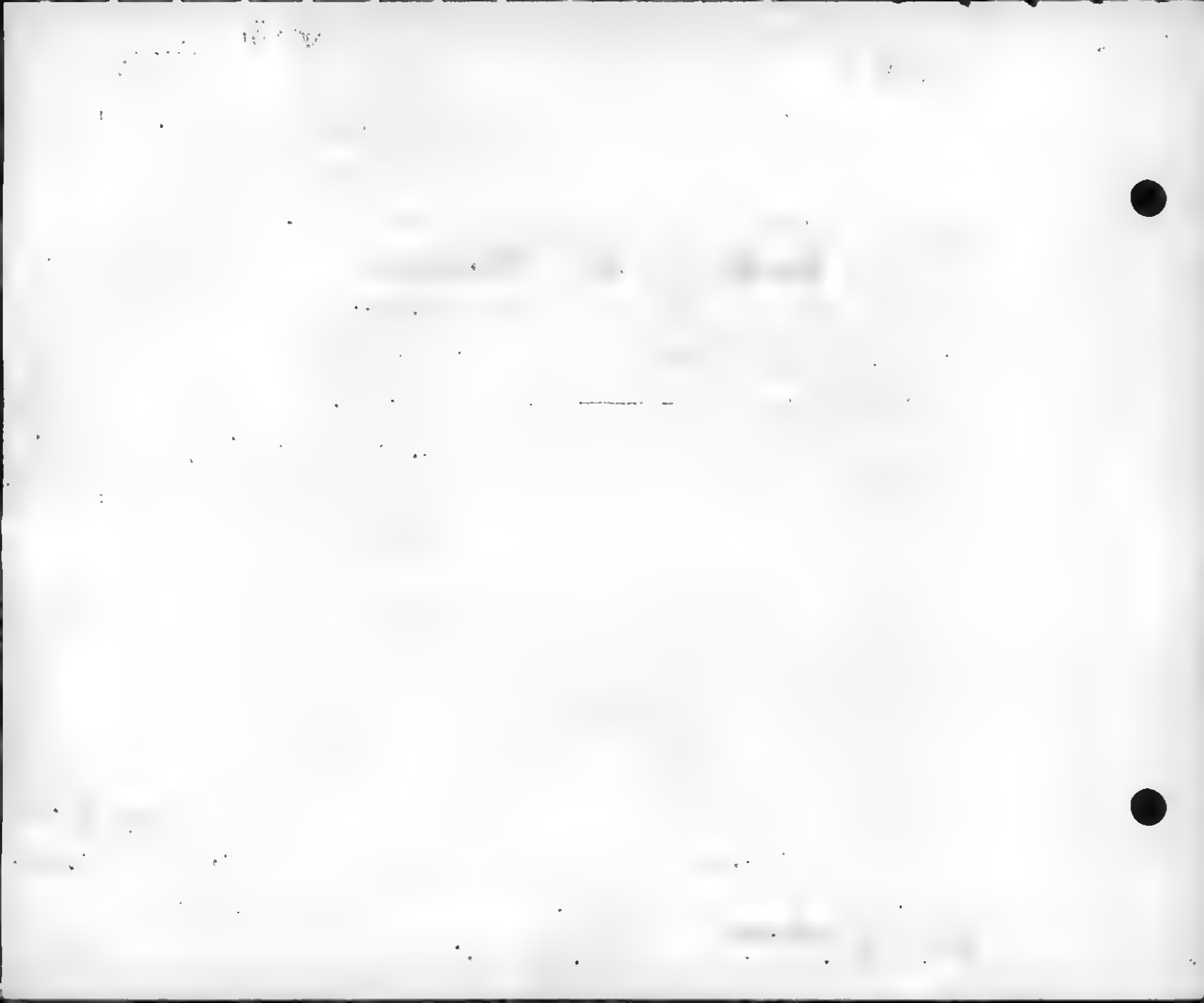
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>Item 18 Film 389 5-29- MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> <div>07096 07076</div>											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs				d. STREET ADDRESS 5211 - Colonial Drive	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5211 - Colonial Drive						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Ruth A. Gibson						4. DATE OF DEATH Month May 19th 19 67					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 6th, 1921		9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months 46 Days 46 Hours 46 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (County & State, or foreign country) Dunkirk, Indiana				12. CITIZEN OF WHAT COUNTRY? usa	
13. FATHER'S NAME Charles Racer						14. MOTHER'S MAIDEN NAME Mary Helen Rectinanus					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO.		17. INFORMANT Curtis A. Gibson (Husband)				Address Same as # 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Original site undetermined DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 6 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from July 1, 1966 to May 19, 1967 , that (I) (we) last saw the deceased alive on May 19, 1967 , and that death occurred at 2:30 M, from the causes and on the date stated above.											
22a. SIGNATURE David N. Robb						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 19, 1967			
22c. PHYSICIAN'S NAME (Type) David N. Robb						22d. ADDRESS 5116 - Middleton Lane, Camp Springs, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 22-1967		23c. NAME OF CEMETERY OR CREMATORY IOOF Cemetery				23d. LOCATION (City, town or county) (State) Dunkirk, Indiana			
24. FUNERAL DIRECTOR Simmons Bros.						ADDRESS 1661 - Good Hope RD. SE Wash. DC		25a. REC'D BY REGISTRAR MAY 22 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07097

CERTIFICATE OF DEATH

07077

1. PLACE OF DEATH a COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c LENGTH OF STAY IN TB 14 days	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d STREET ADDRESS 14-V5 Ridge Road		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First James Middle F. Last Griggs		4 DATE OF DEATH Month May Day 13 , Year 1967					
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 4/13/29	9 AGE (In years last birthday) 38 yrs	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS Hours Min 	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman Griggs		10b. KIND OF BUSINESS OR INDUSTRY Meats		11. BIRTHPLACE (County & State, or foreign country) Ohio		12 CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Emmett R Griggs				14. MOTHER'S MAIDEN NAME Gertrude F Azbell			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Korean		16 SOCIAL SECURITY NO 578 30 8824		17. INFORMANT Betty Jane Griggs		Address Greenbelt, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diphtheria (Pneumonia) of liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ② Acute 2-3 sec oc DUE TO (c) ③ post-canal blunt trauma							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 29 , 1967, to May 13 , 1967, that (I) (we) last saw the deceased alive on May 13 , 1967, and that death occurred at 10:30 AM from causes and on the date stated above.							
22a. SIGNATURE <i>John H Bayly</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 13, 1967			
22c. PHYSICIAN'S NAME (Type) John H. Bayly, M.D.		22d. ADDRESS 1835 Eye St., N.W., Washington, D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 16, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.	
24 FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md				25a. REC'D BY REGISTRAR MAY 17 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

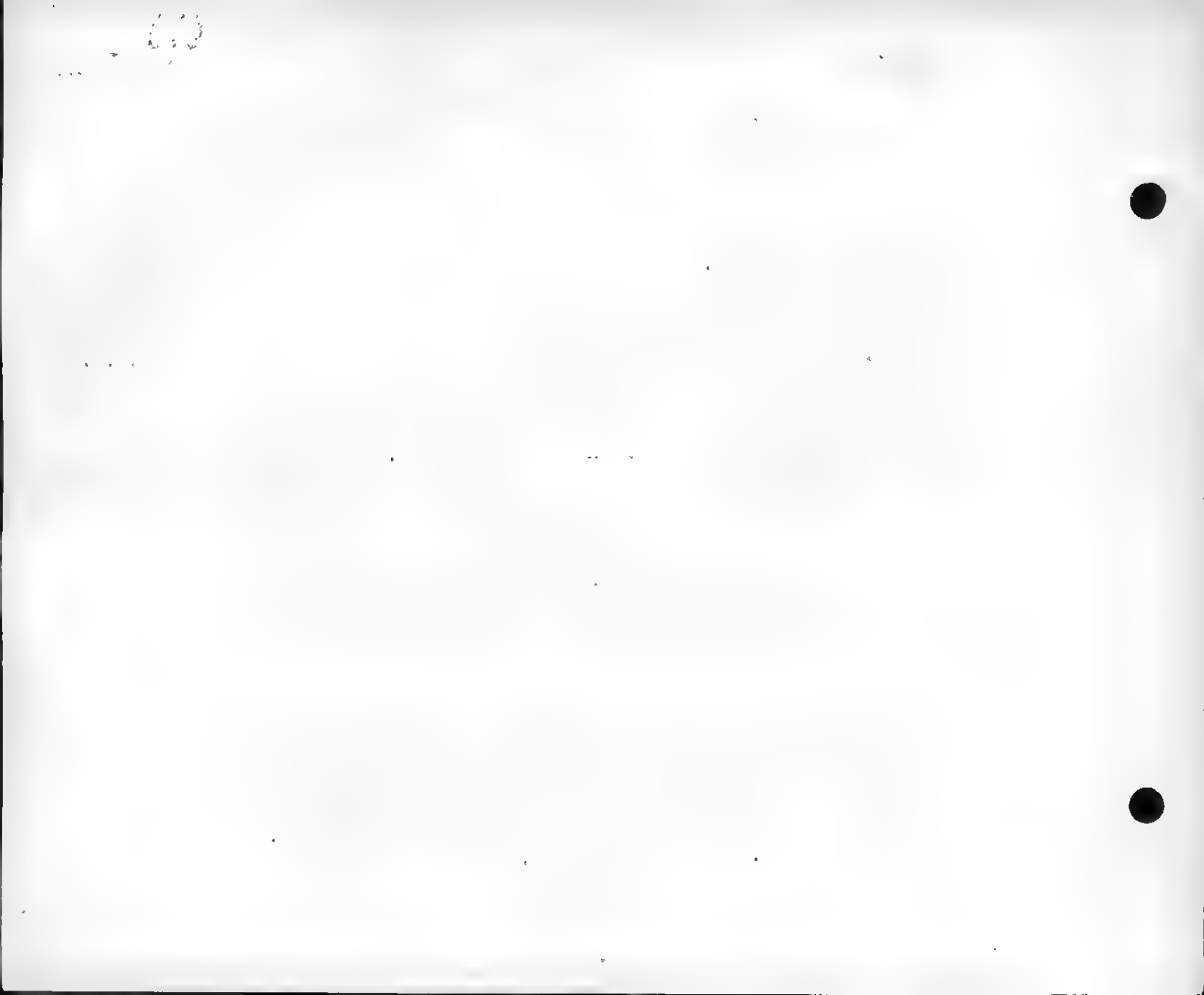
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07098

CERTIFICATE OF DEATH

07078

1 PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews Air Force Base		c. LENGTH OF STAY IN b 6 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSP. ANDREWS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) JOHN J. GRIMES		4 DATE OF DEATH MAY 14, 1967	
5 SEX MALE	6 COLOR OR RACE CAUCASIAN	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 AUG 1889
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if released) LT. MAJOR USA RETIRED		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	
11. BIRTHPLACE (County & State, or foreign country) ROCHESTER NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HOMER GRIMES		14. MOTHER'S MAIDEN NAME SALLY (Unkown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES 1917-1946		16. SOCIAL SECURITY NO 214-28-4270	
17. INFORMANT ESTELLE W. GRIMES -WIFE-Same as # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic Heart Disease DUE TO (c) Ruptured Abd. Aortic Aneurysm			INTERVAL BETWEEN ONSET AND DEATH 10 years 7 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 13 May, 1967, to 14 May, 1967, that (I) (we) last saw the deceased alive on 14 May 1967, and that death occurred at 0130 AM, from causes and on the date stated above.			
22a. SIGNATURE John Bristow		22b. DATE SIGNED 14 May '67	
22c. PHYSICIAN'S NAME (Type) JOHN W. BRISTOW CAPT, USAF, MC		22d. ADDRESS USAF HOSP. ANDREWS ANDREWS AFB, WASHINGTON, DC 20331	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 5/17/1967	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	23d. LOCATION (City or Town) (County) (State) Arlington, Va.
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc. -La Plata, Md		25a. REC'D BY REGISTRAR MAY 19 1967 25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07093

CERTIFICATE OF DEATH

07079

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Andrews Air Force Base			c. LENGTH OF STAY IN lb 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF Hospital Andrews				d. STREET ADDRESS 6219 Nottingham Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBIN RENEE GROSS First Middle Last				4. DATE OF DEATH MAY 13, 1967 Month Day Year			
5. SEX FEMALE		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 5, 1967	
9. AGE (In years last birthday) 6 yrs		10. UNDER 1 YEAR 8 Months		11. UNDER 24 HRS. 8 Days		12. UNDER 24 HRS. 8 Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State or foreign country) Andrews A.F.B. Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Leonard Paul Price				14. MOTHER'S MAIDEN NAME (Never Married) JOAN MAUREEN GROSS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.				16. SOCIAL SECURITY NO. -		17. INFORMANT Mother 6219 Nottingham Drive Camp Springs, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY 7545 IMMEDIATE CAUSE (a) Congenital Heart Disease DUE TO (b) Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) -							INTERVAL BETWEEN ONSET AND DEATH 8 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 5, 1967 to May 13, 1967 , that (I) (we) last saw the deceased alive on May 13, 1967 , and that death occurred at 7:21 PM , from causes and on the date stated above.							
22a. SIGNATURE Phillip Steiner				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED May 13, 1967	
22c. PHYSICIAN'S NAME (Type) PHILLIP STEINER, CAPT, USAF, MC				22d. ADDRESS USAF HOSP. ANDREWS Wash. D.C. 20331			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 5-15-67		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL Cemetery		23d. LOCATION (City or Town) (County) (State) PRINCE GEORGE Md	
24. FUNERAL DIRECTOR Robert E. Wickham F. Howe				ADDRESS 4305 Suitland Rd Suitland Md		25a. REC'D BY REGISTRAR MAY 18 1967	
				25b. REGISTRAR'S SIGNATURE Richard Judge			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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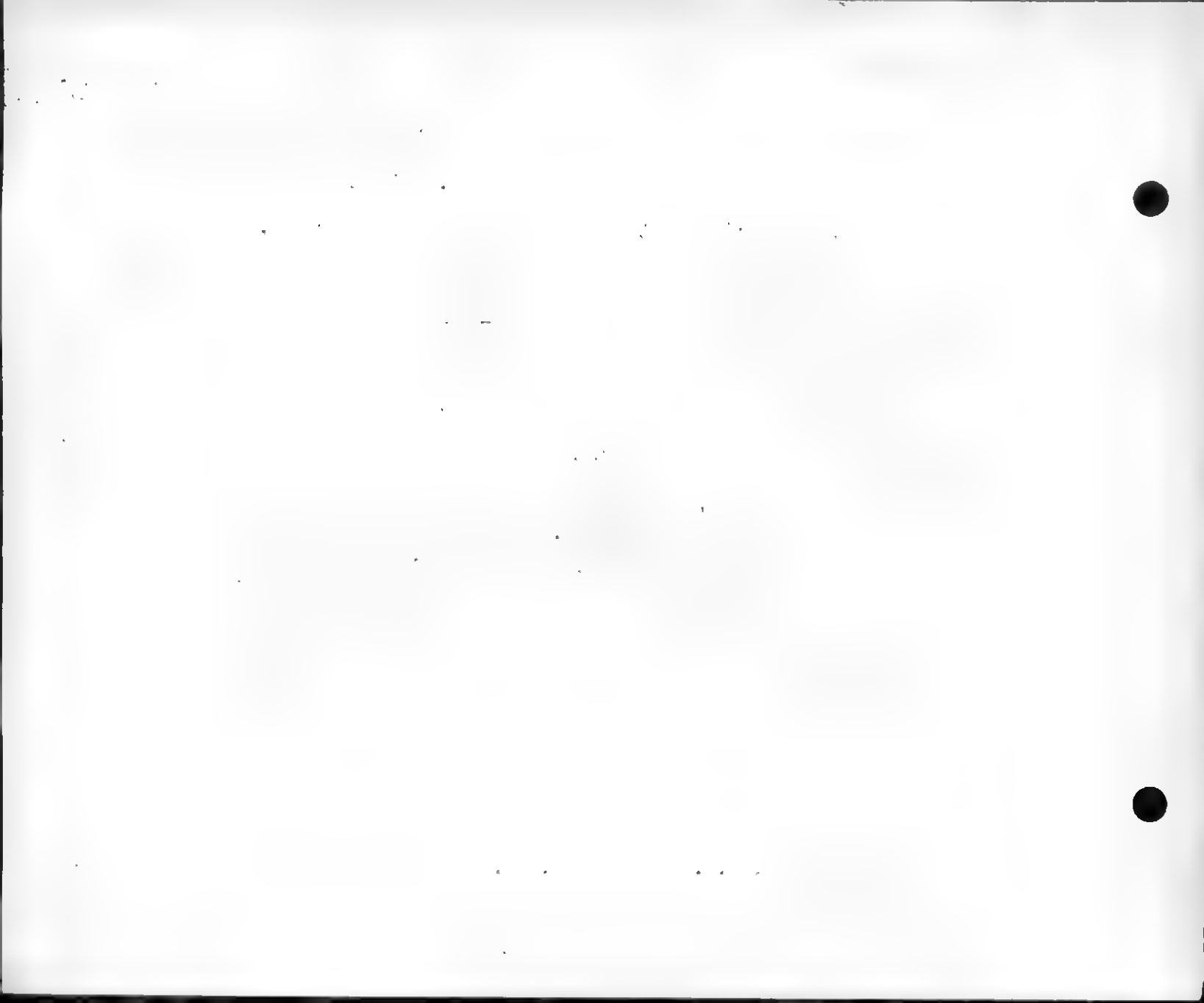
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07:00

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07080

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution; residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Mt. Rainier	
c LENGTH OF STAY IN b DOA		d STREET ADDRESS 4115 Rainier Ave.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Belle Young Haut		4 DATE OF DEATH Month Day Year 5 4 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3-31-1908
9 AGE (In years lost birthday) 59 yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) PENNA.		12 CITIZEN OF WHAT COUNTRY? US	
13 FATHER'S NAME FRED O YOUNG		14 MOTHER'S MAIDEN NAME ELLA WESSER	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 579305135	
17 INFORMANT MRS. BETTY-JO SIEVERT		Address 5106 KENILWORTH AV EDMONSTON, MD	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute thrombotic occlusion of right and left anterior, descending branches (b) And Myocardial infarction, posterior wall (c) From Stenosing coronary arteriosclerosis, severe DLE TO			INTERVAL BETWEEN ONSET AND DEATH minutes days years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D. M.D.		22. DATE SIGNED 5-5-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town or county)	
23a BURIAL, CREMATION, REMOVAL, SPECIFY	23b DATE THEREOF 5-8-1967	23c NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM.	23d LOCATION (City or town) (County) (State) BLADENSBURG, MARYLAND
24 FUNERAL DIRECTOR W.W. CHAMBERS CO. RIVERDALE, MD		25a REC'D BY REGISTRAR MAY 11 1967	
		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07101

CERTIFICATE OF DEATH

07081

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE D.C. b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 77 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital				a. STREET ADDRESS 3721 18th St., N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bessie Middle L. Last Henighan				4. DATE OF DEATH Month May Day 12 Year 19 67			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/4/1916	9. AGE (In years last birthday) 50 yrs	10. IF UNDER 1 YEAR Months 5 Days 12 Hours 19 Min 67		11. IF UNDER 24 HRS Months 5 Days 12 Hours 19 Min 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Austin Henighan				14. MOTHER'S MAIDEN NAME Janie Houston			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 577-20-0526		17. INFORMANT Decedent Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 2890 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) Malignant histiocytosis 6 months						INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary tuberculosis						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work or work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 2-24 , 19 67 , to 5-12 , 19 67 , that (X) (we) last saw the deceased alive on 5/12 , 19 67 , and that death occurred 06:00A.M. from causes and on the date stated above.							
22a. SIGNATURE Moe Weiss				22b. DATE SIGNED 5/12/67		22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.	
22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) 5-15-67		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Charlotte, N.C.		23d. LOCATION (City or town) (County) (State)	
24. FUNERAL DIRECTOR Arazeis Funeral Home 389 R.I. Ave				25a. REC'D BY REGISTRAR MAY 17 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

425



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Deputy Med. Exam. Notified (Dr. John Kehoe) & approved.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #14 & 15 1-13-69 1/23/67 pc

07102

CERTIFICATE OF DEATH

07082

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md b. COUNTY Pro Geo Co	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md.		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) New Carrollton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital		d. STREET ADDRESS 7915 Legation Road	
3 NAME OF DECEASED (Type or print) First Mabel Middle H Last Hess		4 DATE OF DEATH Month May 12, 1967 Day 19 Year 19	
5 SEX female	6 COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept 27, 1900
9 AGE (In years last birthday) yrs 66		F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Self employed	
11 BIRTHPLACE (County & State, or foreign country) Pennsylvania		12 CITIZEN OF WHAT COUNTRY? U S A	
13 FATHER'S NAME Maris Hoskins		14. MOTHER'S MAIDEN NAME Victoria Dorsey Daily	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes		16 SOCIAL SECURITY NO 577 30 7535	
17 INFORMANT Donald H Hess		Address New Carrollton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction, Acute DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 15 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/26, 1957, to May 2, 1967, that (I) (we) last saw the deceased alive on May 2, 1967, and that death occurred at 4:05 PM, from causes and on the date stated above.			
22a. SIGNATURE Gordon W Kelley		22b. DATE SIGNED May 12-1967	
22c. PHYSICIAN'S NAME (Type) Gordon W Kelley		22d. ADDRESS 6124 41th ave Hyattsville, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF May 16, 1967	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington Arlington Va
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR MAY 17 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

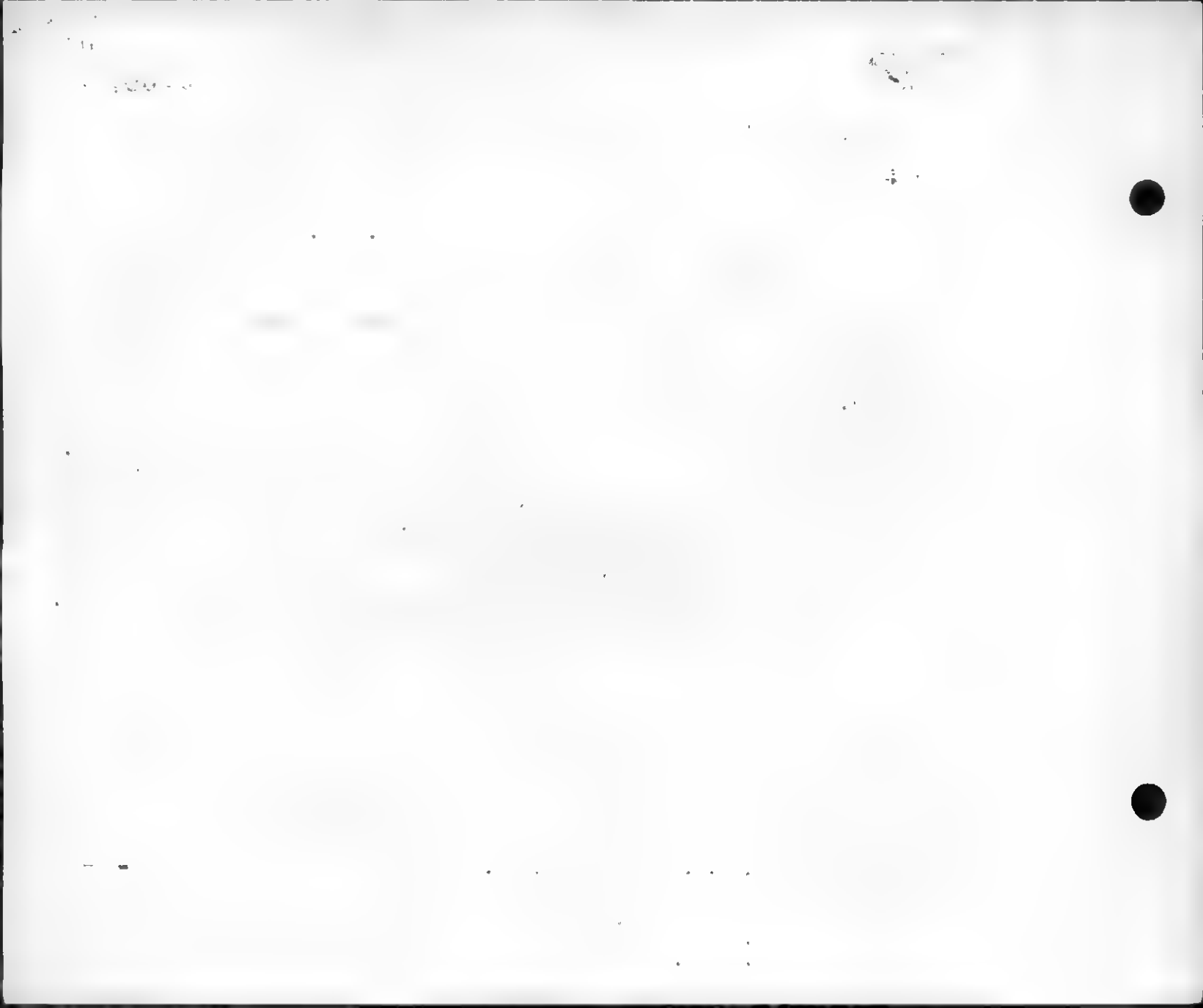
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07103

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07083

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN b. DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				e. STREET ADDRESS 4909 66th. Ave.			
3 NAME OF DECEASED (Type or print) First Alfred Middle Moore Last Hicks				4. DATE OF DEATH Month 5 Day 19 Year 1967			
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 June 1924		9. AGE (In years last birthday) 42 yrs	IF UNDER 1 YEAR Months 16 Days 1 Hours 67 Min	
10a. USUA. OCCUPATION (Give kind of work done during most of work life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) North Carolina		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Wallie O. Hicks				14 MOTHER'S MAIDEN NAME Lena F. Moore			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Benjamin A. Posey Address 4813 67th Ave. Landover, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shock and hemorrhage DUE TO Rupture of oesophageal varices Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last From portal hypertension DUE TO From Cirrhosis of liver (c) From Chronic alcoholism							INTERVAL BETWEEN ONSET AND DEATH minutes minutes months years 20 yrs.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WA. AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D. M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town or county) 5-19-67			
23a. BURIAL, CREMATION, REMOVAL, SPECIFY burial		23b. DATE THEREOF 5/22/67		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges County, Md.	
24 FUNERAL DIRECTOR The S.H. Hines Company Address 2901 14th St. N.W. Washington, D.C.				25a. REGISTRATION DATE MAY 22 1967		25b. REGISTRAR SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07104

CERTIFICATE OF DEATH

07084

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE SIGNED WITH PERMISSION OF
DR. KEHDE - ASST. MED. EXAMINER

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>P. GEO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>				c. LENGTH OF STAY IN b. <u>13 YRS.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7629 CHRIS-MAR AVE</u>				d. STREET ADDRESS <u>CLINTON,</u> <u>11.1</u>			
3. NAME OF DECEASED (Type or print) <u>JAMES A. HILL</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 11, 1928</u>	
9. AGE (In years last birthday) <u>38</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. POST OFFICE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>CHAS. CO. MARYLAND</u>	
13. FATHER'S NAME <u>FRANK C. HILL</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE BUCKLER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO <u>213-22-2407</u>		17. INFORMANT <u>WIFE</u> <u>BERNICE P. HILL</u> Address <u>7629 CHRIS-MAR AVE CLINTON</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO (b) <u>ARTERIOSCLEROTIC-CARDIOVASCULAR DISEASE - WITH HEALED MYOCARDIAL INFARCTION</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN.</u> <u>10 MIN.</u> <u>1 YEAR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NONE</u>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>NONE</u>			
20c. TIME OF INJURY Month, Day, Year Hour, a.m. <u>NONE</u>				20d. INJURY OCCURRED While <u>NONE</u> of work <u>NONE</u>		20e. PLACE OF INJURY (Home, farm, factory, street, other, other, other) <u>NONE</u>	
20f. (City or town) <u>NONE</u>				20g. (County) <u>NONE</u>		20h. (State) <u>NONE</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>AUG 25, 1966</u> to <u>PRESENT</u> , that (I) (we) last saw the deceased alive on <u>APRIL 22, 1967</u> , and that death occurred at <u>4:50 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Arthur Shaver Jr.</u>				22b. DATE SIGNED <u>May 2, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>ARTHUR SHAYER JR.</u>	
22d. ADDRESS <u>8808 OLD BRANCH AVE. CLINTON MD</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 6th 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington Nat'l. Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>Simmons Bros.</u>				25a. REC'D BY REGISTRAR <u>MAY 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
25c. ADDRESS <u>Simmons Bros. 1661-Good Hope Rd SE Wash DC</u>				25d. DATE <u>MAY 5 1967</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 3

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #13 Film #37105

07105

CERTIFICATE OF DEATH

07085

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 6413 Allegany Ave.			
3. NAME OF DECEASED (Type or print) First Middle Last Roy R. Hiner				4. DATE OF DEATH Month Day Year May 24, 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 Oct. 1930		9. AGE (In years lost birthday) 36 yrs	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, then if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Takoma Fuel		11. BIRTHPLACE (County & State or foreign country) Takoma Park		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Raymond Hiner				14. MOTHER'S MAIDEN NAME Virginia Beck			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Raymond S. Hiner Address 203 Monroe			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Encephalitis of LIVER DUE TO (c)							
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (he) (this hospital) attended the deceased from May 16, 1967 , to May 24, 1967 , that (he) (we) last saw the deceased alive on May 24, 1967 , and that death occurred at 6:45 AM , from causes and on the date stated above.							
22a. SIGNATURE W. Hernandez MD				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) T. J. Hernandez, MD	
22d. ADDRESS Prince Georges General Hospital				22e. REC'D BY REGISTRAR Charles Judge			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF May 26-1967		23c. NAME OF CEMETERY OR CREMATORY Lack Creek		23d. LOCATION (City or Town) (County) (State) Washington DC	
24. FUNERAL DIRECTOR Charles Judge		25a. ADDRESS 254 Canal St NW		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAY 29 1967	

12.1.1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07106

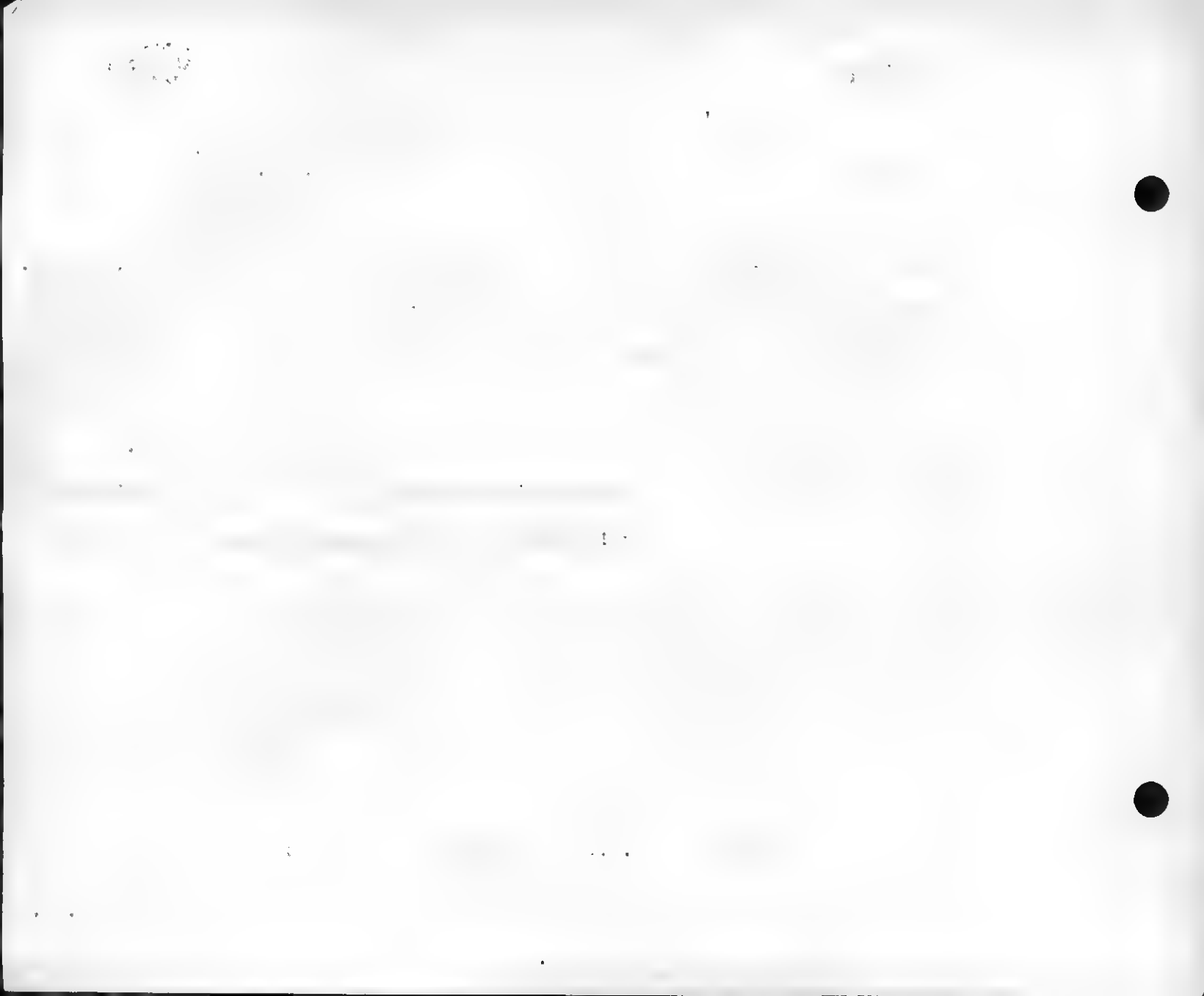
07086

FOR STATE HEALTH DEPT.

1 PLACE OF DEATH a COUNTY Prince George's b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg, Cheverly c LENGTH OF STAY IN 1b D O A		2 USUAL RESIDENCE (Where deceased lived if institution or residence before admission) a STATE Maryland b COUNTY Pro George's c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg, Md.	
3 NAME OF DECEASED (Type or print) Ruth Land Hoke		4 DATE OF DEATH Month May Day 6 Year 19 67.	
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Dec 24, 1908
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales clerk		10b KIND OF BUSINESS OR INDUSTRY Interior Decorator	
11 BIRTHPLACE (State or foreign country) South Carolina		12 CITIZEN OF WHAT COUNTRY? U S A.	
13 FATHER'S NAME ? Land		14 MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO 578 28 8651	
17 INFORMANT Robert Hoke		Address Bladensburg, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Subarachnoid hemorrhage DUE TO (b) Hypertensive cardio vascular disease DUE TO (c) Unknown		INTERVAL BETWEEN DEATH AND EXAMINATION Minutes	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D., Riverdale		22. DATE SIGNED 5-7-67	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF May 9, 1967	23c NAME OF CEMETERY OR CREMATORY Stanley Cemetery	23d LOCATION (City or town) (County) (State) Stanley Gaston N. C.
24 FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a REC'D BY REGISTRAR MAY 10 1967	25b REGISTRAR'S SIGNATURE Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

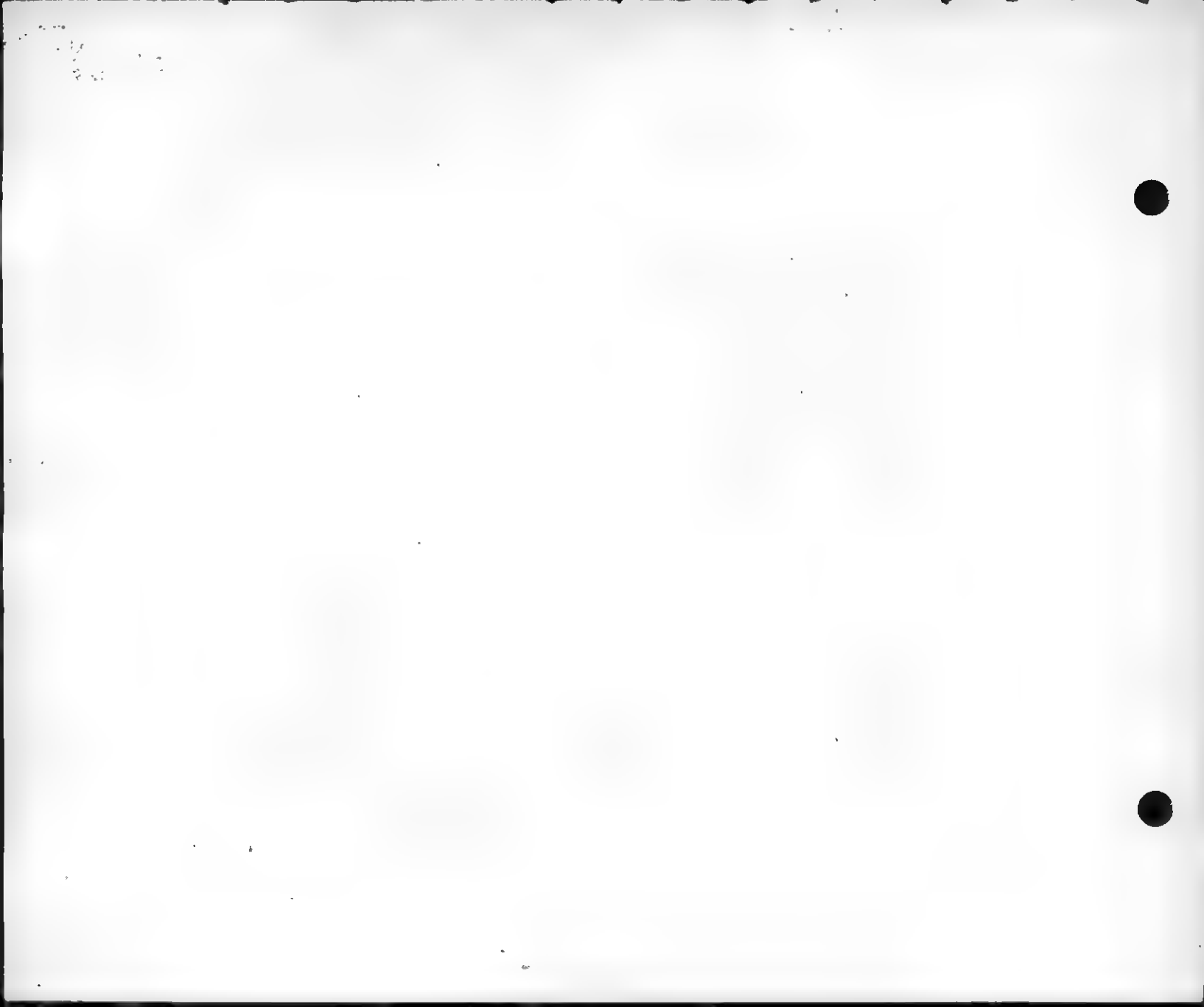
07107

CERTIFICATE OF DEATH

07087

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u> c. LENGTH OF STAY IN ID d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u> d. STREET ADDRESS <u>Rt. 10 Box 435</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Robert Briscoe</u> First <u>Holiday</u> Middle Last			4. DATE OF DEATH <u>May</u> Month <u>18</u> Day <u>1967</u> Year				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Feb. 24, 1911</u>		9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Prince George Co., Md.</u>			
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME <u>John L. Holliday</u>				
14. MOTHER'S MAIDEN NAME <u>Hattie Greenlief</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)				
16. SOCIAL SECURITY NO. <u>218-12-7694</u>			17. INFORMANT <u>Milton Holliday</u> Address <u>Rt. 1-Box 435 Brandywine, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diagnosed as such</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year <u> </u> <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>5-16</u> , 19 <u>67</u> , to <u>5-18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-18</u> , 19 <u>67</u> , and that death occurred at <u>3:00</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard H. Dobs on</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Richard H. Dobs on</u>				22d. ADDRESS <u>Brandywine, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 20, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gibbons Meth. Ch. Cem.</u>			
23d. LOCATION (City, town or county) <u>Brandywine Pr. Geo. Md.</u>		23e. (State)					
24. FUNERAL DIRECTOR <u>Martell Adams</u> <u>Aquasco, Maryland</u>				25a. REC'D BY REGISTRAR <u>MAY 24 1967</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							



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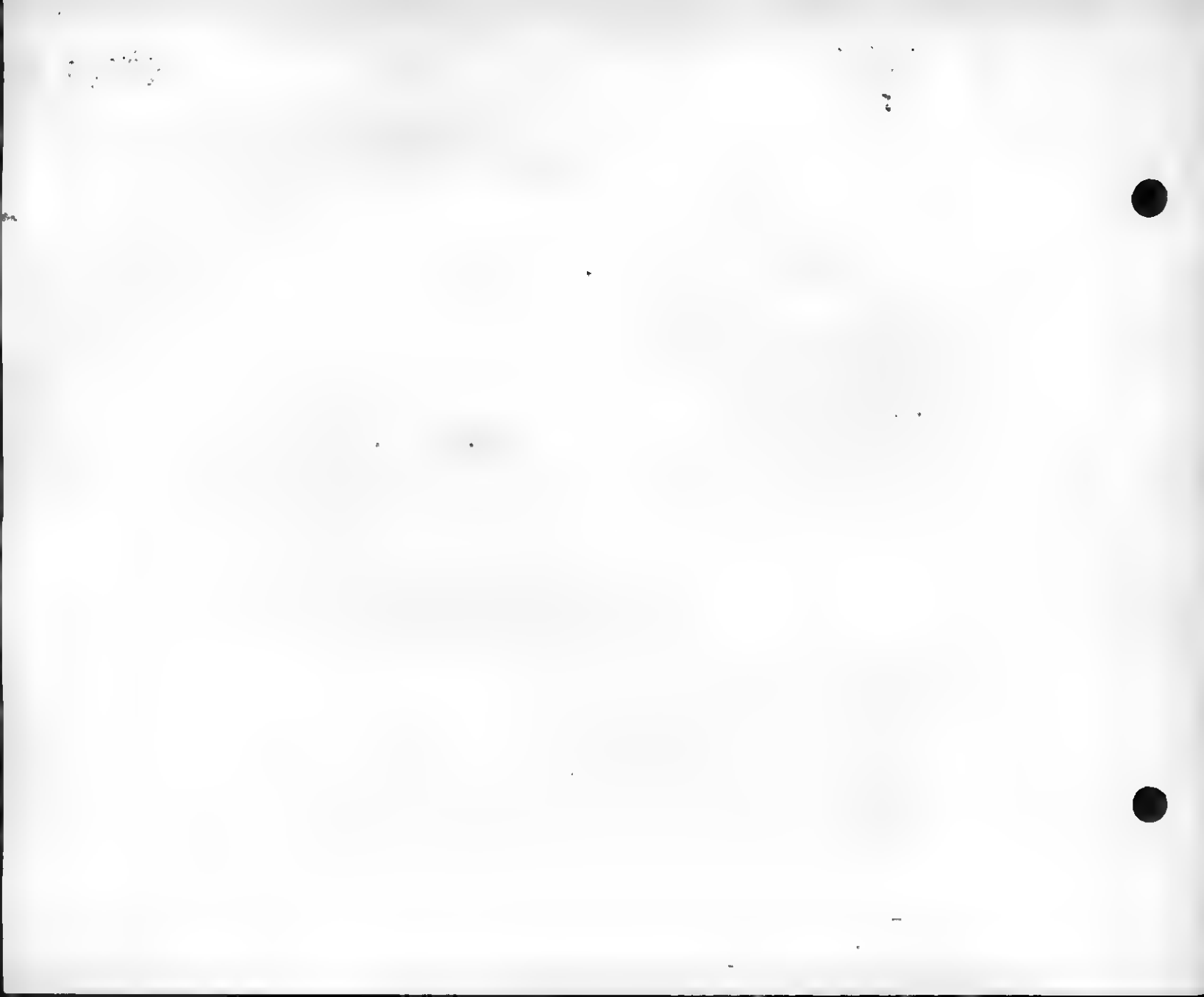
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07108

CERTIFICATE OF DEATH

07088

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE MARYLAND b. COUNTY PRINCE GEORGES		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AF BASE		c. LENGTH OF STAY IN IT 35 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOWIE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS			d. STREET ADDRESS 3540 MADONA LANE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JOYCE T. HOPPE			4. DATE OF DEATH Month Day Year MAY 11 19 67		
5. SEX FEMALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 JUN 35		9. AGE (In years last birthday) 31 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (County & State, or foreign country) BIRMINGHAM, ALABAMA	
13. FATHER'S NAME S.E. Thompson			14. MOTHER'S MAIDEN NAME LILLIAN HORSLEY		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO NA		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Capt. Louis A. Hoppe HUSBAND Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1258 RENAL AND HEPATIC FAILURE DUE TO (b) METASTATIC CARCINOMA DUE TO (c) ADENOCARCINOMA OF COLON					INTERVAL BETWEEN ONSET AND DEATH 1 Month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that this (this hospital) attended the deceased from 6 April, 19 67 to 11 May, 1967, that (s) (we) last saw the deceased alive on 11 May 19 67, and that death occurred at 0:25M from causes on and on the date stated above. A.M.					
22a. SIGNATURE Warren E. Johnson		22b. DATE SIGNED 11 May 1967		22c. PHYSICIAN'S NAME (Type) WARREN E. JOHNSON, CAPT, USAF MC	
22d. ADDRESS USAF Hospital Andrews Andrews AFB Wash DC 20331		22e. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial		23b. DATE THEREOF May 15, 1967		23c. NAME OF CEMETERY OR CREMATORY Spring Grove Cemetery	
23d. LOCATION (City or town) Cincinnati		23e. (County) Hamilton		23f. (State) Ohio	
24a. REC'D BY REGISTRAR MAY 15 1967		24b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07109

CERTIFICATE OF DEATH

07089

1 PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVEELEY</u>		c. LENGTH OF STAY IN 1b <u>14 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PRINCE GEORGES' GENERAL HOSP.</u>		d. STREET ADDRESS <u>2302 BERKLEY ST.</u>	
3 NAME OF DECEASED (Type or print) <u>Joseph J. Howard</u>		4. DATE OF DEATH <u>May 20 1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>87 10-17-1899</u>
9 AGE (In years, months, days) <u>79 yrs</u>		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Ret. Engineer Penn. R.R.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Penn. R.R.</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Charles Joseph Howard</u>		14. MOTHER'S MAIDEN NAME <u>Susan Ella Jennings</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>RESSEY L. HOWARD</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the lungs</u> 11-3X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/6</u> , 19 <u>67</u> , to <u>5/20</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>5/20</u> , 19 <u>67</u> , and that death occurred at <u>5:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Hernandez MD</u>		22b. DATE SIGNED <u>5/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>T. J. HERNANDEZ MD</u>		22d. ADDRESS <u>PGG II</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
<u>BURIAL</u>	<u>5-23-67</u>	<u>Birchwood Cem.</u>	<u>ROXBORO, N.C.</u>
24. FUNERAL DIRECTOR <u>LEE FUNERAL HOME 300 45TH ST</u>		25a. REC'D BY REGISTRAR <u>DATE MAY 25 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07110

07090

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived if not in residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN 1b DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e STREET ADDRESS 25-G Ridge Road	
3 NAME OF DECEASED (Type or print) First Middle Last Marvin John Huffman		4 DATE OF DEATH Month Day Year 5 28 19 67	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9 AGE (In years last birthday) yrs 28
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WELDER		10b KIND OF BUSINESS OR AMERICAN IRON WORKS	
11 BIRTHPLACE (State or foreign country) WASH. D.C.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME RALEIGH R. HUFFMAN		14 MOTHER'S MAIDEN NAME RETA BISHOP	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO 214-36-2619	
17 INFORMANT Dorothy L. Huffman		Address Wife Same as #2	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sub-arachnoid hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Rupture of aneurysm of circle of Willis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH MINUTES			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day Year Hour min pm 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office, playground, etc.)	20f CITY OR TOWN (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county)	
22. DATE SIGNED 5-28-67			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF 5-31-67	23c NAME OF CEMETERY OR CREMATORY FT. LINCOLN	23d LOCATION (City or Town) (County) (State) COLMAR MANOR, MARYLAND
24 FUNERAL DIRECTOR GASCH'S 4739 Baltimore Ave. Hyattsville, Md.		25a REC'D BY REGISTRAR MAY 31 1967	25b REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

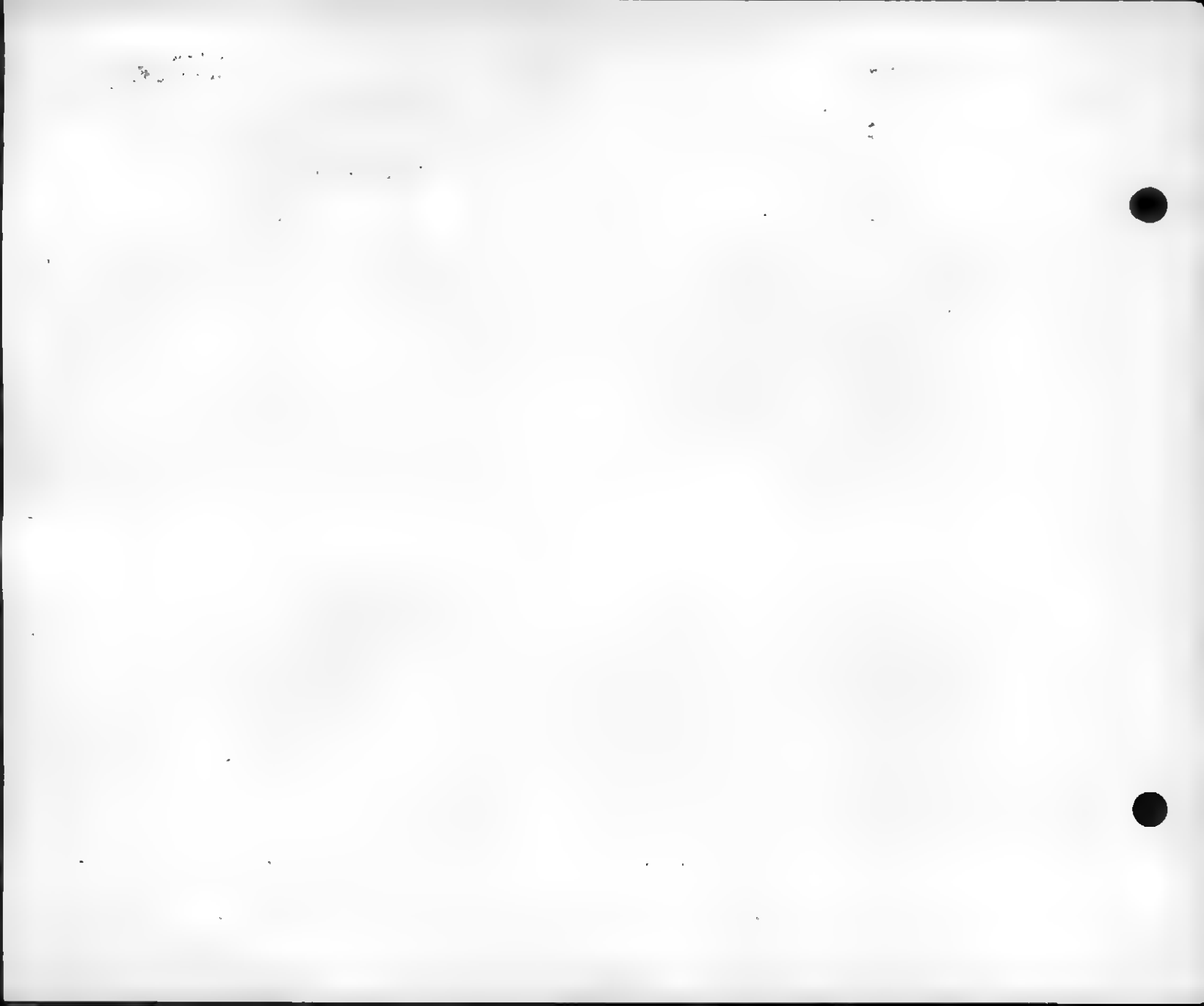
07111

CERTIFICATE OF DEATH

07091

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Prince George's			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c LENGTH OF STAY IN 1b 1 day		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d STREET ADDRESS 5104 72nd Avenue		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Catherine Middle (Humphries) Last Humphreys				4 DATE OF DEATH Month May Day 5 Year 19 67			
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4/17/80		9 AGE (in years last birthday) 87 yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) D.C.		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME Samuel H. Atwell				14 MOTHER'S MAIDEN NAME Sarah E. Cole			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no no		16 SOCIAL SECURITY NO.		17 INFORMANT Address Robert C. Humphried same as # 2.D			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 12:01 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3-4 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) AL B D G R I N A L T C A C I L						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 19 67 to May 5, 19 67 , that (I) (we) last saw the deceased alive on 19 67 , and that death occurred at 10:15 PM from causes and on the date stated above.							
22a SIGNATURE Albert Roth, M. D.				22b DATE SIGNED MAY 10 1967		22c PHYSICIAN'S NAME (Type) Albert Roth, M. D.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 5.9.67		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d LOCATION (City or town) (County) (State) Suitland, Maryland	
24 FUNERAL DIRECTOR Lee Funeral Home, Wash D.C.				25a REC'D BY REGISTRAR MAY 10 1967		25b REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT.

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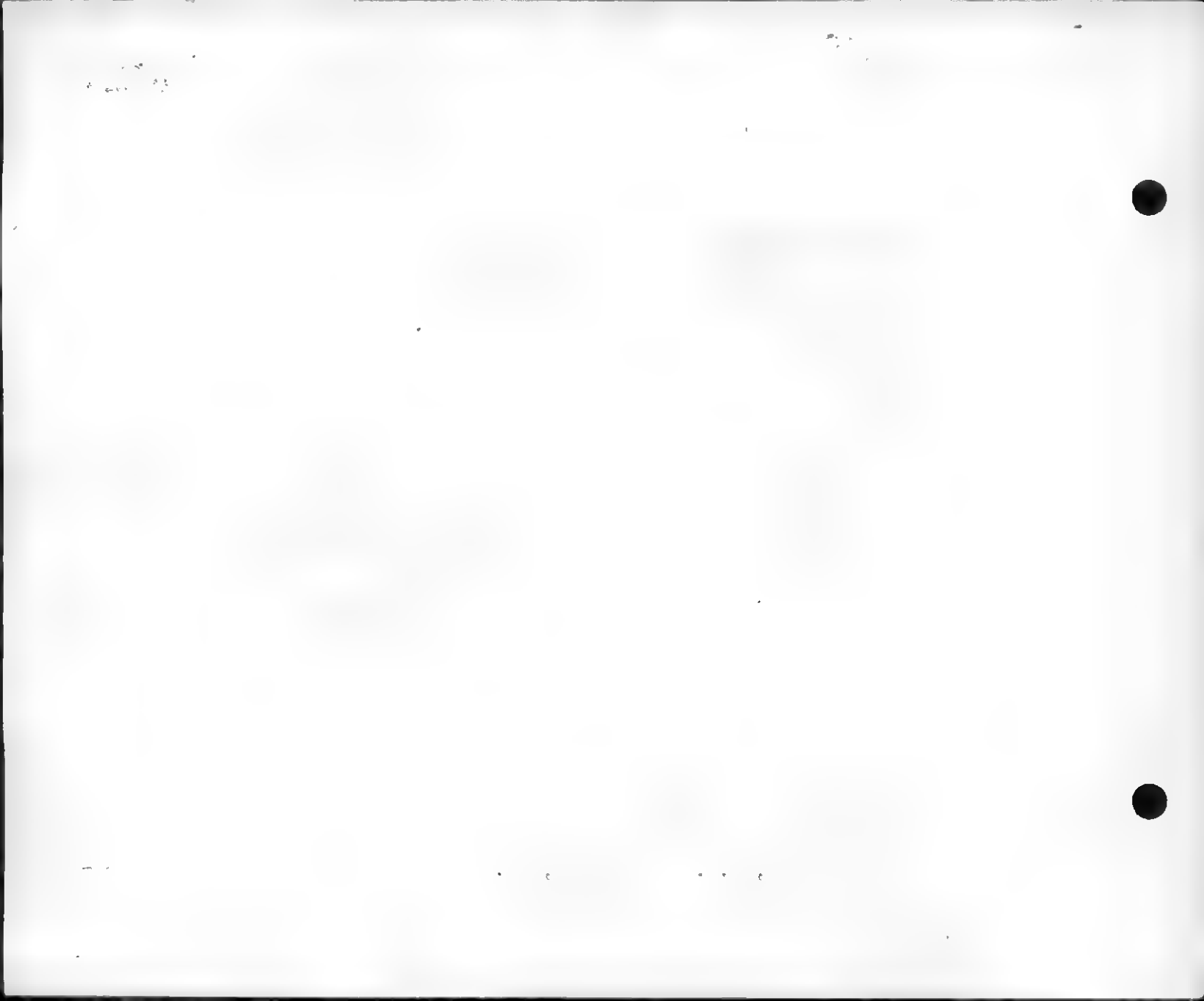
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 18, File #388 5/19/67

07112

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07092

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside	
c. LENGTH OF STAY IN DOA		d. STREET ADDRESS 5287 Marlboro Pike	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Deborah Lynn Jewell		4 DATE OF DEATH 5 2 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10 Jan. 1967
9 AGE (In years last birthday) 3		10 IF UNDER 1 YEAR 3 Months Days Hours Min	
11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		11b KIND OF BUSINESS OR INDUSTRY NONE	
11 BIRTHPLACE (State or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME DONALD E JEWELL		14 MOTHER'S MAIDEN NAME ALICE GALLISON	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16 SOCIAL SECURITY NO NONE	
17 INFORMANT DONALD E JEWELL		Address SAME AS 2-D	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I DEATH WAS CAUSED BY			
IMMEDIATE CAUSE (a) 492x DUE TO Pneumonitis			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (SDII) Due to Diplococcus pneumoniae			
DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 5-2-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a BURIAL CREMATION BURIAL	23b DATE THEREOF 5-5-67	23c NAME OF CEMETERY OR CREMATORY HOLLEY CEMETERY	23d LOCATION (City or town) (County) (State) HOLLEY NEW YORK
24 FUNERAL DIRECTOR W. Chambers		25a REC'D BY REGISTRAR MAY 5 1967	
Address 517-11 1/2 St SE Wash, DC.		25b REGISTRAR'S SIGNATURE J. Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

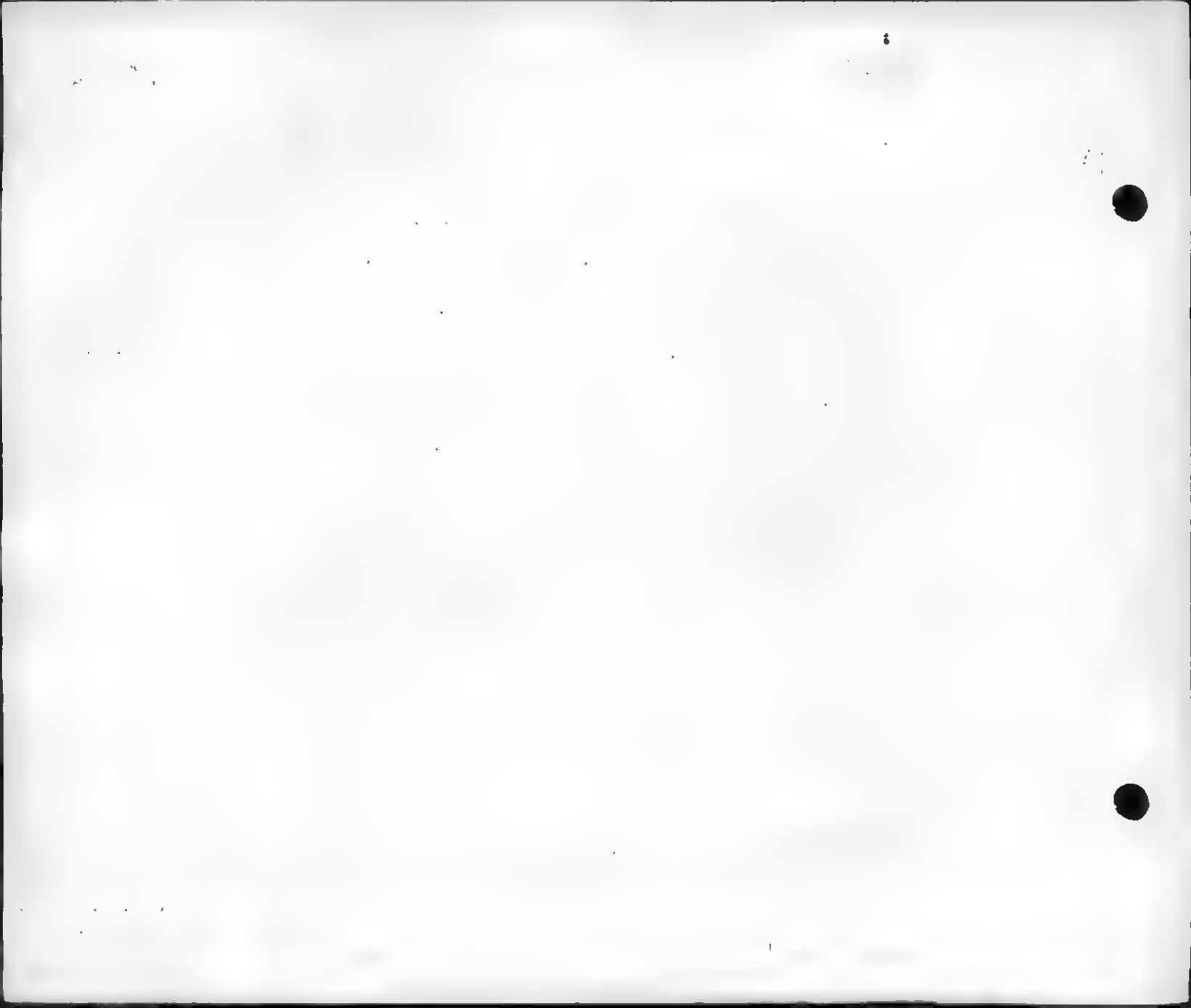
07113

CERTIFICATE OF DEATH

07093

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS R. F. D. # 172	
3. NAME OF DECEASED (Type or print) George First B. Middle Johnson Sr. Last		4. DATE OF DEATH May Month 2, Day 19 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 6, 1904
9. AGE (In years last birthday) 63 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10b. KIND OF BUSINESS OR INDUSTRY D. of Government	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Thomas F. Johnson		14. MOTHER'S MAIDEN NAME Adeline McCoy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 216 46 0371	
17. INFORMANT May E. Johnson		414 Brightseat Road Lanham, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) White Coronary Thrombosis DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) last Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 2, 1967 to Jan 3, 1967 , that (I) (we) last saw the deceased alive on Jan 2, 1967 , and that death occurred at 2:20 P.M. from causes and on the date stated above.			
22a. SIGNATURE Aaron Deitz		22b. DATE SIGNED 5-367	
22c. PHYSICIAN'S NAME (Type) Aaron Deitz, M. D.		22d. ADDRESS Prince George Plaza Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/6/67	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	23d. LOCATION (City or Town) (County) (State) Colmar Manor P. G. Md.
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR MAY 5 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07114

CERTIFICATE OF DEATH

07094

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier Riverdale			c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial				d. STREET ADDRESS 4100 - 30th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Loraine Middle Ruby Last Johnson				4. DATE OF DEATH Month 5- Day 6 Year 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-10-20	
9. AGE (In years last birthday) 47 yrs		10. IF UNDER 1 YEAR Months 47 Days 47 Hours 47 Min 47		11. BIRTHPLACE (County & State, or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Va.	
13. FATHER'S NAME Jeff Moore				14. MOTHER'S MAIDEN NAME Minnie Susan Adams			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown				16. SOCIAL SECURITY NO. 277-24-7728		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE PANCREATITIS 5-10 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FORMAL DISEASE CONDITION GIVEN IN PART I (a) HEMORRHAGIC GASTRITIS, LIVER FAILURE OBESITY							INTERVAL BETWEEN ONSET AND DEATH 2 DAYS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-6 , 19 67 , to 5-7 , 19 67 , that (I) (we) last saw the deceased alive on 5-7 19 67 , and that death occurred at 11:45 AM, from causes and on the date stated above.							
22a. SIGNATURE C. J. Houmann				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 5-7-67	
22c. PHYSICIAN'S NAME (Type) C. J. HOUMANN				22d. ADDRESS RIVERDALE			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/10/67		23c. NAME OF CEMETERY OR CREMATORY East Lincoln Cem.		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR Valley's Funeral Home				25a. REC'D BY REGISTRAR MAY 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>1 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>07115</p> </div> <div> <p>2 MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>3 07095</p> </div> </div>											
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>PRINCE GEORGE COUNTY</u> MARYLAND</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</p> <p>c. LENGTH OF STAY IN 1b <u>DOA</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ANDREWS AIR FORCE BASE HOSPITAL</u></p>					<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u></p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CAMP SPRINGS</u></p> <p>d. STREET ADDRESS <u>5205 COLUMBIA TERRACE</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>						
<p>3. NAME OF DECEASED (Type or print)</p> <p>First <u>HAROLD</u> Middle <u>RICHARD</u> Last <u>JONES</u></p>					<p>4. DATE OF DEATH</p> <p>Month <u>MAY</u> Day <u>20</u> Year <u>1967</u></p>						
<p>5. SEX <u>MALE</u></p>		<p>6. COLOR OR RACE <u>WHITE</u></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>25 JULY 1899</u></p>		<p>9. AGE (In years last birthday) <u>67</u> yrs.</p>		<p>IF UNDER 1 YEAR: Months <u>67</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u></p>		<p>11. BIRTHPLACE (County & State, or foreign country) <u>MASSACHUSETTS</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>			
<p>13. FATHER'S NAME <u>HARRY JONES</u></p>					<p>14. MOTHER'S MAIDEN NAME <u>CHARLOTTE MALONE</u></p>						
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u></p>				<p>16. SOCIAL SECURITY NO. <u>008 03 4270</u></p>		<p>17. INFORMANT <u>MARIE V. JONES</u> Address <u>CAMP SPRINGS, MD.</u></p>					
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u></p> <p>4201 DUE TO (b) <u>Arteriosclerotic Heart Disease</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)</p>										<p>INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>											
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>							
<p>20c. TIME OF INJURY Month, Day, Year</p> <p>Hour a.m. <u>19</u> p.m.</p>			<p>20d. INJURY OCCURRED</p> <p>While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work</p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>				
<p>21. I certify that (I) (this hospital) attended the deceased from <u>12-4, 1966</u> to <u>5-20, 1967</u>, that (I) (we) last saw the deceased alive on <u>5-16, 1967</u>, and that death occurred at <u>2230</u> M, from the causes and on the date stated above.</p>											
<p>22a. SIGNATURE <u>Fredrick L. Sachs</u> M.D.</p>					<p>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></p>		<p>22b. DATE SIGNED <u>5-21-67</u></p>				
<p>22c. PHYSICIAN'S NAME (Type) <u>FREDERICK L. SACHS</u></p>					<p>22d. ADDRESS <u>ANDREWS AIR FORCE BASE HOSP.</u></p>						
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u></p>			<p>23b. DATE THEREOF <u>5/21/67</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN</u></p>		<p>23d. LOCATION (City, town or county) (State) <u>BLADENSBURG, MD.</u></p>				
<p>24. FUNERAL DIRECTOR <u>W.W. CHAMBERS CO. INC.</u></p>			<p>ADDRESS <u>5TH ST. S.E. WASH. D.C.</u></p>		<p>25a. REC'D BY REGISTRAR <u>MAY 25 1967</u></p>		<p>25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u></p>				

4178

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

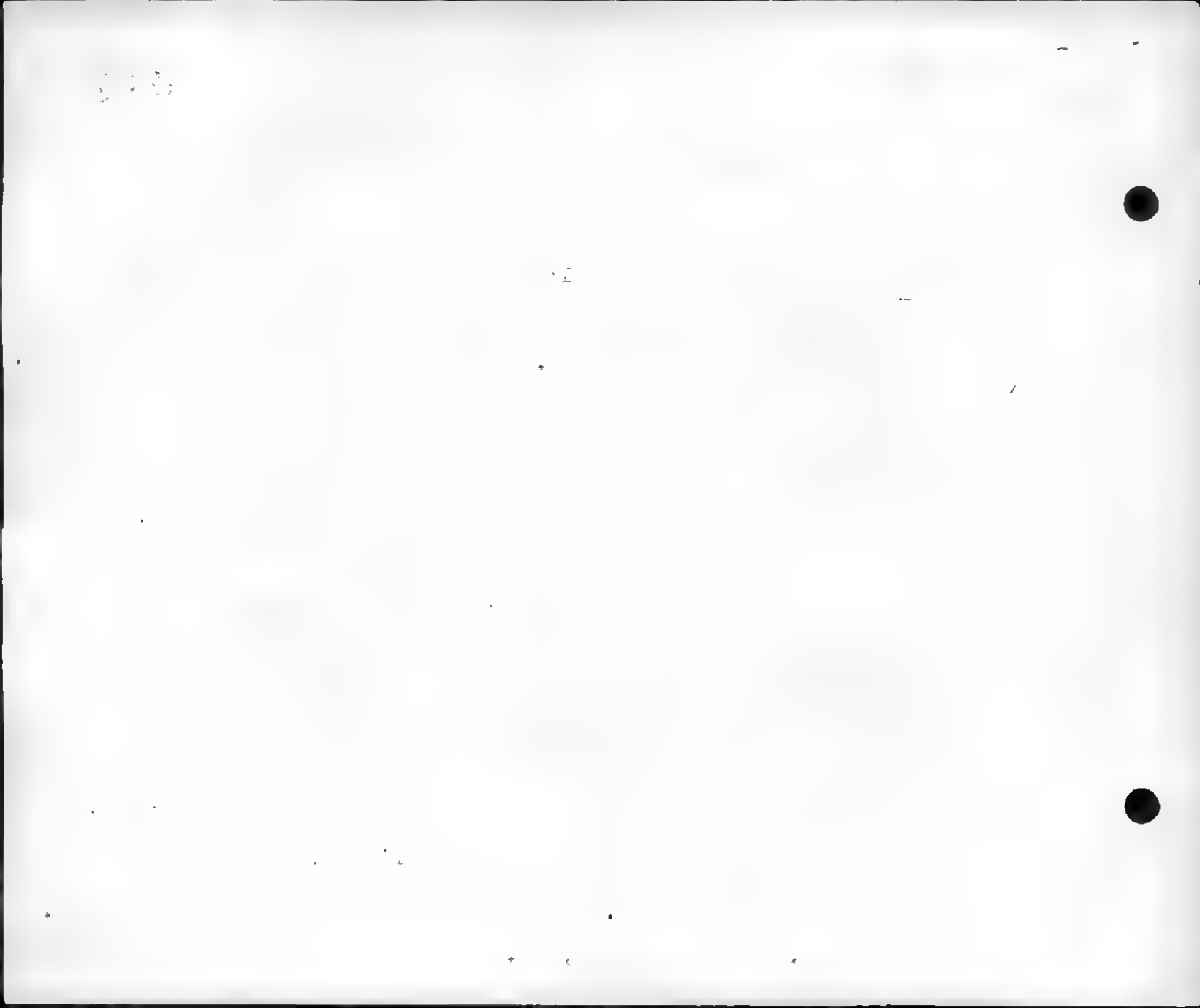
07116

07096

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UPPER MARLBORO (RURAL)</u>	
c. LENGTH OF STAY IN 1b <u>2 months 11 days</u>		d. STREET ADDRESS <u>Box 4612</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PineView Gardens Health Care Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALTA</u> Middle <u>TOL</u> Last <u>JOWETT</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-15-1989</u>
9. AGE (In years last birthday) <u>78</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>PRINCE GEORGES, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>CLINTON BEALL</u>		14. MOTHER'S MAIDEN NAME <u>MARY DUCKETT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>MRS WILTON T. JOWETT</u>		Address <u>Box 4612 UPPER MARLBORO, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> DUE TO (b) <u>Arteriosclerotic Heart Disease 6 mmibs</u> DUE TO (c) <u>Senility</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mmibs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2-28</u> , 19 <u>67</u> , to <u>5-13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-13</u> , 19 <u>67</u> , and that death occurred at <u>1:55 PM</u> , from causes on and on the date stated above			
22a. SIGNATURE <u>Alfred R. Lapin</u> M.D.		22b. DATE SIGNED <u>5/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN, MD</u>		22d. ADDRESS <u>Clinton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/16/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Groom Md.</u>
24. FUNERAL DIRECTOR <u>Ritchie Bros. Upper Marlboro, Md.</u>		25. REC'D BY REGISTRAR <u>MAY 18 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

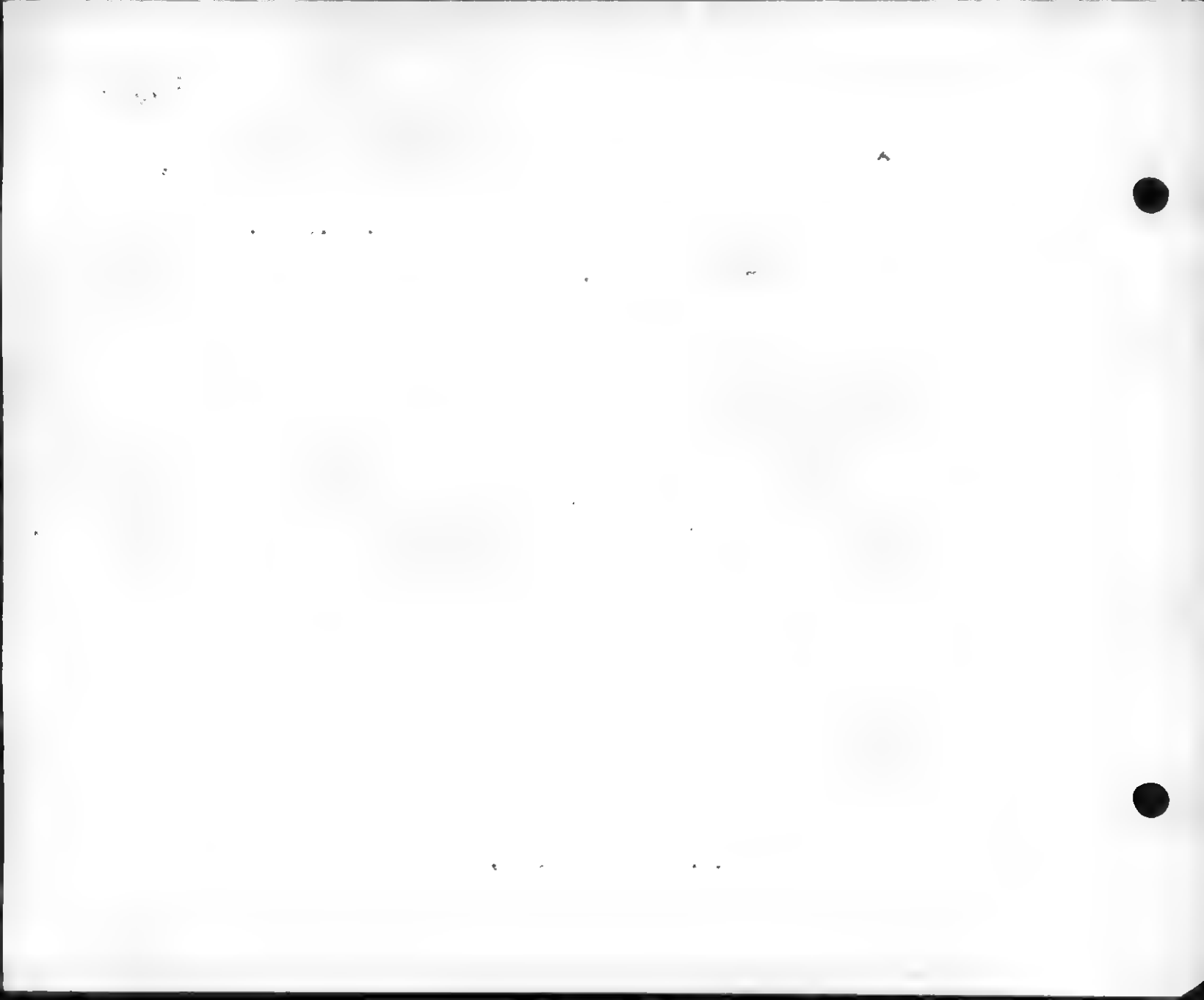
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07117		07097	
1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE District of Columbia b COUNTY <input checked="" type="checkbox"/>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN 1b DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George General Hospital		d STREET ADDRESS 1300 44th. Pl., S.E.	
3 NAME OF DECEASED (Type or print) Marion H. Kagey		4 DATE OF DEATH Month 5 Day 3 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8-15-1898
9 AGE (In years last birthday) 68 yrs		10 IF UNDER 1 YEAR Months 5 Days 3 Hours 19 Min 67	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Rhode Island	
11 BIRTHPLACE (State or foreign country)		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME Gabriel Morrison		14 MOTHER'S MAIDEN NAME McDonald	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16 SOCIAL SECURITY NO no	
17 INFORMANT Samuel W. Kagey		Address same as D.2	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) INTERVAL BETWEEN ONSET AND DEATH minutes over 5 yrs.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D. M.D.		22. DATE SIGNED 5-4-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 5.6.67	23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d LOCATION (City or Town) (County) (State) Suitland Maryland
24 FUNERAL DIRECTOR Lee Funeral Home 300.4th st N E		25a REC'D BY REGISTRAR MAY 8 1967	
		25b REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

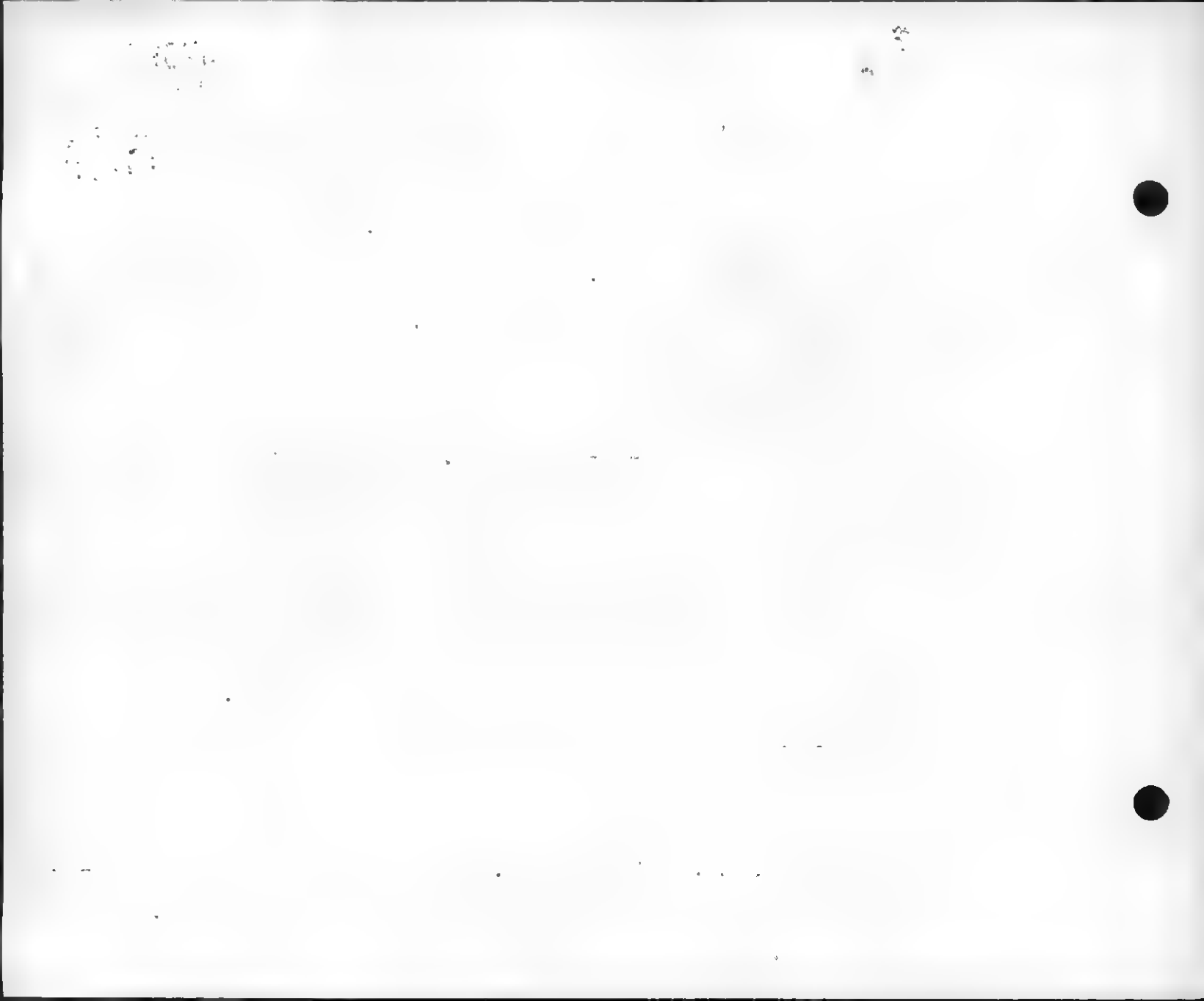
07118

07098

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale			c. LENGTH OF STAY IN 1b 11 days		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital			e. STREET ADDRESS 9033 48th. Place		
3. NAME OF DECEASED (Type or print) First Aubrey Middle J. Last Kendall			4. DATE OF DEATH Month 5 Day 29 Year 19 67		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 Jan. 1909	9. AGE (In years last birthday) 58 yrs	10. IF UNDER 1 YEAR Months 16 Days 1 Hours 1 Min 1
10a. USUAL OCCUPATION (Give kind of work done by deceased if not in hospital, give nearest town) Retired Postal Clerk U.S.G.			11. BIRTHPLACE (State or foreign country) Washington, D.C.		
10b. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Jausha Wilder Kendall			14. MOTHER'S MAIDEN NAME Irene Connors		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOC. SECURITY NO. 578-05-2978		
17. INFORMANT Mrs. Rachel U. Kendall (above address)			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gun shot wound of head 976x DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 11 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Shot self in head in bedroom of home.		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 4:15am p.m. 5-18-19 67			20d. INJURY OCCURRED Where <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home			20f. (City or town) (County) (State) same as #2		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe			22. DATE SIGNED 5-30-67		
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.			Address (Street, city, town, or county)		
23a. BURIAL, CREMATION, or other disposition Burial	23b. DATE THEREOF 6/1/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	23d. LOCATION (City or town) (County) (State) Suitland, Md.		
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.			25a. REC'D BY REGISTRAR DATE JUN 5 1967		
ADDRESS Mt. Rainier, Maryland			25b. REGISTRAR'S SIGNATURE Charles Judge		

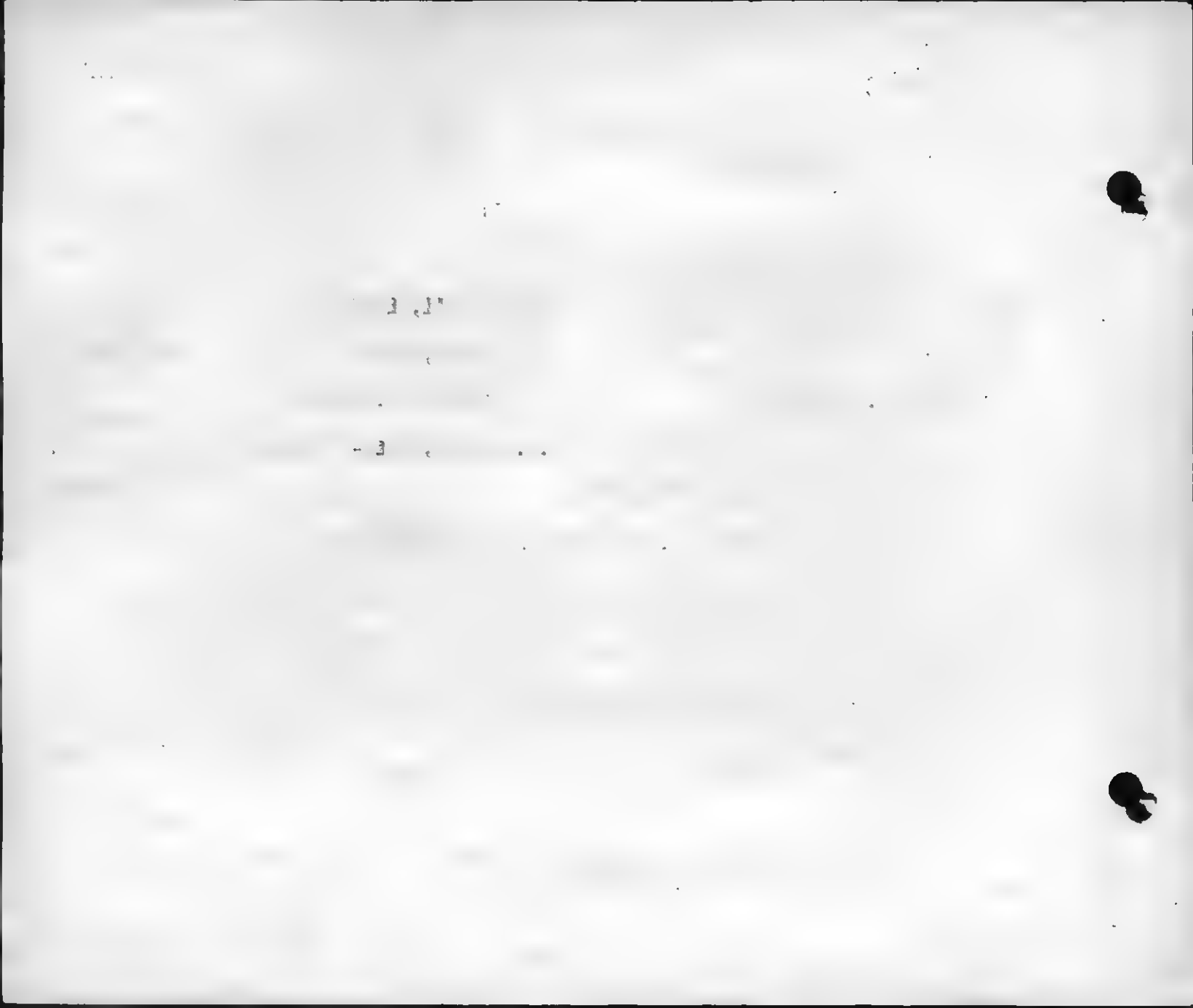
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL CERTIFICATION ■

VR A15 (4)
15M 7/61



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07100

FOR STATE HEALTH DEPT.

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN Td DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d STREET ADDRESS 3851 St. Barnabas Rd.	
3 NAME OF DECEASED (Type or print) First Herbert Middle H Last Kidd		4 DATE OF DEATH Month 5 Day 24 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5-2-1897
9 AGE (In years last birthday) 70		10 UNDER 1 YEAR Months 1 Days 24 Hours 19 Min 67	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME William F. Kidd		14. MOTHER'S MAIDEN NAME Georgie Windsor	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT Alba L. Kidd		Address Same As # 2	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4300 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH minutes unknown
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Indetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 5-25-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street city, town, or county) Riverdale, Md.	
23a BURIAL CREMATION REMOVAL (See 1y) Burial	23b DATE THEREOF 5/27/67	23c NAME OF CEMETERY OR CREMATORY Washington National	23d LOCATION (City or Town) (County) (State) Prince Georges, Maryland
24 FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home		25a REC'D BY REGISTRAR MAY 29 1967	
Address 4308 Suitland Road, Suitland, Maryland		25b REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11. 1. 1961

11. 1. 1961

11. 1. 1961



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VII A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07121		07101	
1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN TOWN 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d STREET ADDRESS 400 - 64th Avenue	
3 NAME OF DECEASED (Type or print) First Hattie Middle B Last Knight		4. DATE OF DEATH Month May Day 2 Year 19 67	
5. SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 May 1888
9 AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME William Heflin		14 MOTHER'S MAIDEN NAME Sarah	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No None		16 SOCIAL SECURITY NO 579-16-5784	
17. INFORMANT Mrs Lee Thompson		Address 510 61st Ave. Capitol Hgts. Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular Accident 4/2/67 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic Cardiovascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from April 30, 1967 , to May 2, 1967 , that (X) (we) last saw the deceased alive on May 2, 1967 , and that death occurred at 12.07 AM from causes and on the date stated above.			
22a. SIGNATURE W. W. Chambers		22b DATE SIGNED 5/2/67	
22c PHYSICIAN'S NAME (Type) Dr. Tomas Hernandez		22d ADDRESS Prince Georges General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/5/1967	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	
23d. LOCATION (City or Town) (County) (State) Bladensburg, Maryland.		23e REC'D BY REGISTRAR Charles Judge	
24 FUNERAL DIRECTOR W. W. Chambers		24b REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the bon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07122

07102

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE'S</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE'S</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRADBURY HGHTS</u>				c. LENGTH OF STAY IN 1b <u>13 YRS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5206 BYERS ST.</u>				d. STREET ADDRESS <u>5206 BYERS ST</u>			
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>MAY</u> Last <u>KREYTER</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>9</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 6 1881</u>	9. AGE (In years last birthday) <u>86 yrs.</u>	IF UNDER 1 YEAR Months <u>86</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>GEORGE REIDY</u>				14. MOTHER'S MAIDEN NAME <u>MARY BUCKLER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-68-7568T</u>		17. INFORMANT <u>GEORGE P. SIMMONS</u>		Address <u>SAME AS #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Coronary Ischemia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>104 M</u> <u>20-30 Y</u> <u>10 Y</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Upper Resp. Army Infection</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> , <u>19</u> to <u>MAY 9, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 19, 1966</u> , and that death occurred at <u>9P</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Thomas F. Cullen</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>May 9, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas F. Cullen, M.D.</u>				22d. ADDRESS <u>5103 Marlboro Rd. Se, Wash. D.C. 20027</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY 12, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON NATIONAL</u>		23d. LOCATION (City, town or county) (State) <u>SOITLAND, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS Co</u>				ADDRESS <u>RIVERDALE, MD</u>		25a. REC'D BY REGISTRAR <u>MAY 15 1967</u>	
						25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07123

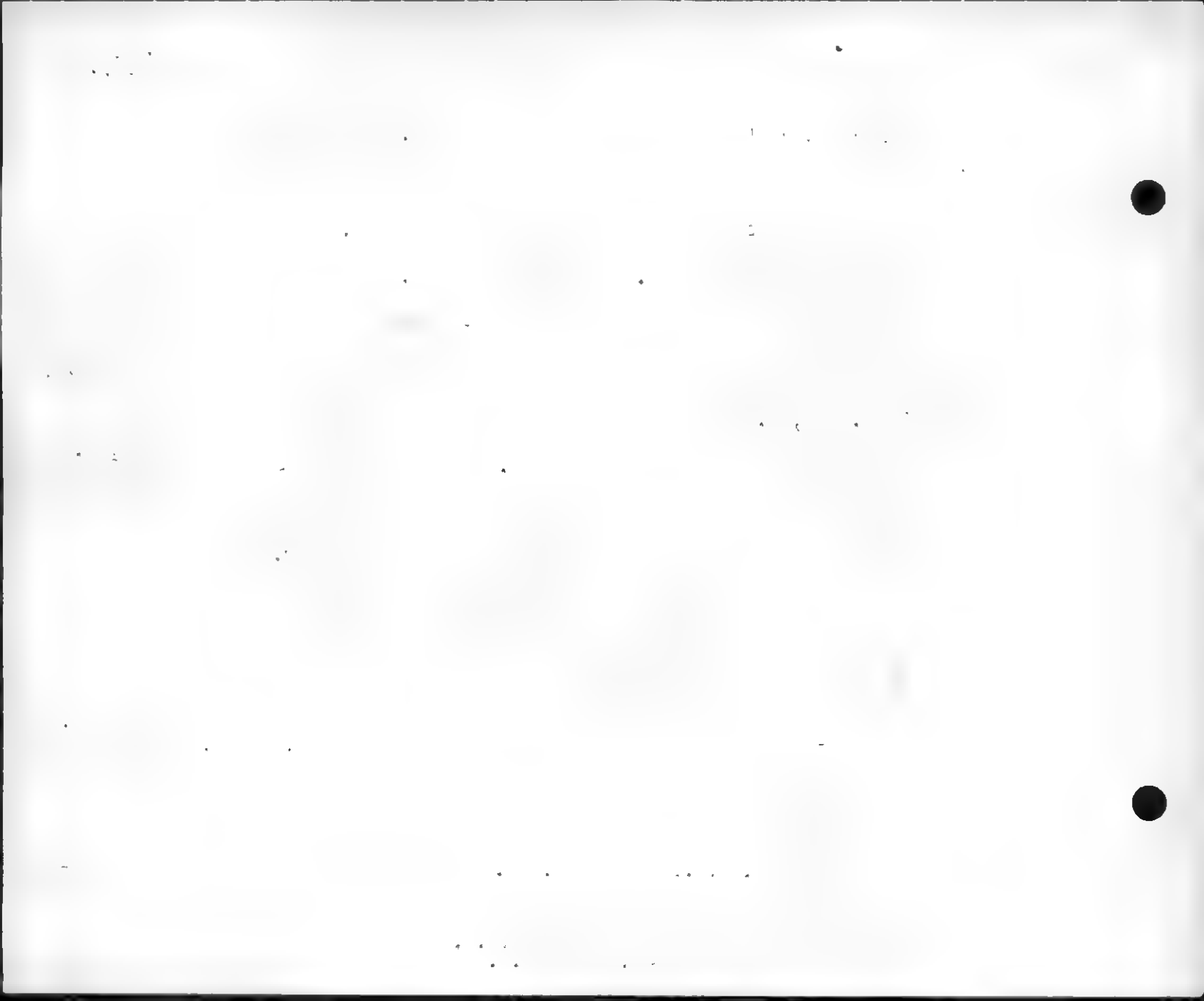
07103

FOR STATE
HEALTH DEPT.

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Penna. b. COUNTY E RIE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Lake City	
c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Arthur Middle M. Last Kunz JR.		4 DATE OF DEATH Month 5 Day 11 Year 19 67	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11-15-1946
9 AGE (In years last birthday) 20		10 IF UNDER 1 YEAR Months 11 Days 19 Hours 67	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b KIND OF BUSINESS OR INDUSTRY STUDENT	
11 BIRTHPLACE (State or foreign country) ERIE, PENNSYLVANIA		12 CITIZENSHIP WHAT COUNTRY? UNITED STATES	
13 FATHER'S NAME ARTHUR M. KUNZ, SR.		14 MOTHER'S MAIDEN NAME MABEL HOLIDAY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17 INFORMANT (FRIEND) R. VAN VLIET		Address SILVER SPRING, MD. 12520 EASTBOURNE DRIVE	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest DUE TO Status post operative repair of laceration of liver. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Trauma (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			9 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Collided with other baseball player	
20c TIME OF INJURY Month, Day Year Hour a.m. 5:30pm 5-8-67 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) Base ball field, Univ. Of Md., College Park	20f (City or town) Prince George Co. (County) Prince George Co. (State) Prince George Co.
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 5-12-67	
EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) GIRARD, PENNSYLVANIA	
23a BURIAL, CREMATION, REMOVAL Specify BURIAL	23b DATE THEREOF 5/15/1967	23c NAME OF CEMETERY OR CREMATORY GIRARD, PENNSYLVANIA	
24 FUNERAL DIRECTOR HYSONG'S FUNERAL HOME		25a REC'D BY REGISTRAR Charles Judge	
ADDRESS WASH. D.C. N. STREET, N.W.		25b REGISTRAR'S SIGNATURE Charles Judge	
DATE MAY 15 1967			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

07124

07104

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington, D. C. b. COUNTY Washington, D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 11 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS 500 0 St., N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James		First Middle Last H. Lawson		4. DATE OF DEATH Month 5 Day 6 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3/23/1901		9. AGE (In years last birthday) 66 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY last employed-Ft. Belvoir		11. BIRTHPLACE (County & State, or foreign country) Spottsylvania, Va.	
13. FATHER'S NAME Elmore Lawson		14. MOTHER'S MAIDEN NAME Cora Stanley		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 726-12-1772		17. INFORMANT Decedent	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary tuberculosis, far advanced DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 yrs.			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized atherosclerosis with atherosclerotic heart disease; diabetes mellitus; bilateral above-knee amputations, right 1962, left 1964.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (X) (this hospital) attended the deceased from 5/4/ , 19 56 , to 5/6/ , 19 67 , that (X) (we) last saw the deceased alive on 5/6/ 1967 , and that death occurred at 12 noon from causes and on the date stated above					
22a. SIGNATURE Moe Weiss		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 5/6/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) 5/10/67		23b. DATE OF BURIAL		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial	
23d. LOCATION (City or Town) Landover, Md.		23e. (County)		23f. (State)	
24. FUNERAL DIRECTOR Tracy H. F. H.		ADDRESS 389 R. A. Ave.		25a. REC'D BY REGISTRAR MAY 12 1967	
25b. REGISTRAR'S SIGNATURE Charles J. J.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

7-11-12
11-12-13

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07125

CERTIFICATE OF DEATH

07105

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Prince George's				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 31 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Lanham Hills				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 7725 Garrison Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) First Melvin Middle L. Last (Sr.) Leizear				4 DATE OF DEATH Month May Day 20 Year 19 67				
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 2/26/06		9 AGE (in years last birthday) 61 yrs	10 IF UNDER 1 YEAR Months Days Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Plumbing		11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.		
13 FATHER'S NAME Robert B. Lizear				14 MOTHER'S MAIDEN NAME Daisey E. Johnson				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16 SOCIAL SECURITY NO 578 10 8996		17. INFORMANT Gertrude E. Leizear		Address Same as #2 (wife)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest 5-21X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Abscesses with Septicemia DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from April 19 , 19 67 , to May 20 , 19 67 , that (1) (we) last saw the deceased alive on May 20 , 19 67 , and that death occurred at 7:55 M. from causes on and on the date stated above.								
22a. SIGNATURE <i>Edwin J. Jensen</i> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/20/67		
22c. PHYSICIAN'S NAME (Type) Edwin J. Jensen, M.D.				22d. ADDRESS Cheverly, Maryland Prince George's General Hospital				
23a. BURIAL, CREMATION, EMBALM (Specify) BURIAL		23b. DATE THEREOF 5/23/67	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.			
24. FUNERAL DIRECTOR Hyattsville, Maryland Francis Gasch's Sons				25a. REC'D BY REGISTRAR DATE MAY 22 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

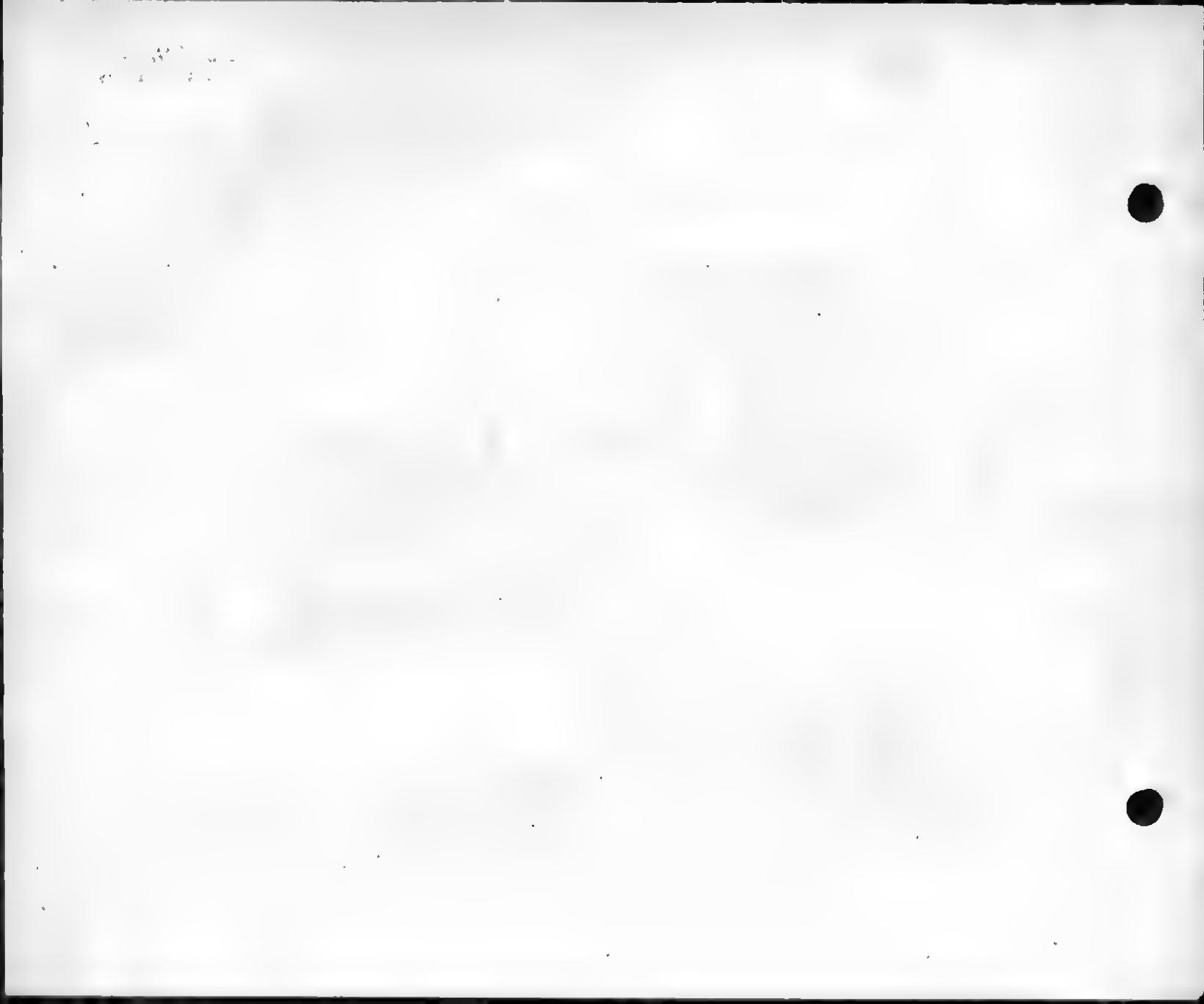


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
07126 CERTIFICATE OF DEATH 07106

1. PLACE OF DEATH a. COUNTY Prince George				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Heights Estate		c. LENGTH OF STAY IN 1b 12 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Heights Estate			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3907 Commander Drive				d. STREET ADDRESS 3907 Commander Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Kate Day		First Middle Last		4. DATE OF DEATH May 13 1967		5. SEX Female	
6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12 Sept 1869		9. AGE (In years last birthday) 97 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home maker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Shannon Co Tenn.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry Bledsoe Day				14. MOTHER'S MAIDEN NAME Catherine Monell Day			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 220-54-2386		17. INFORMANT Katherine Day 3907 Commander Drive			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4330 DUE TO (b) Progressive neurocirculatory failure DUE TO (c) generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH Several days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1955, 19 to 13 May, 1967, that (I) (we) last saw the deceased alive on 12 May, 1967, and that death occurred at 4a.m. from the causes and on the date stated above.							
22a. SIGNATURE Thomas F. Mattingly M.D.				22b. DATE SIGNED 13 May 67		22c. PHYSICIAN'S NAME (Type) Thomas F. Mattingly M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 16, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR MAY 17 1967		25b. REGISTRAR'S SIGNATURE James J. [Signature]	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

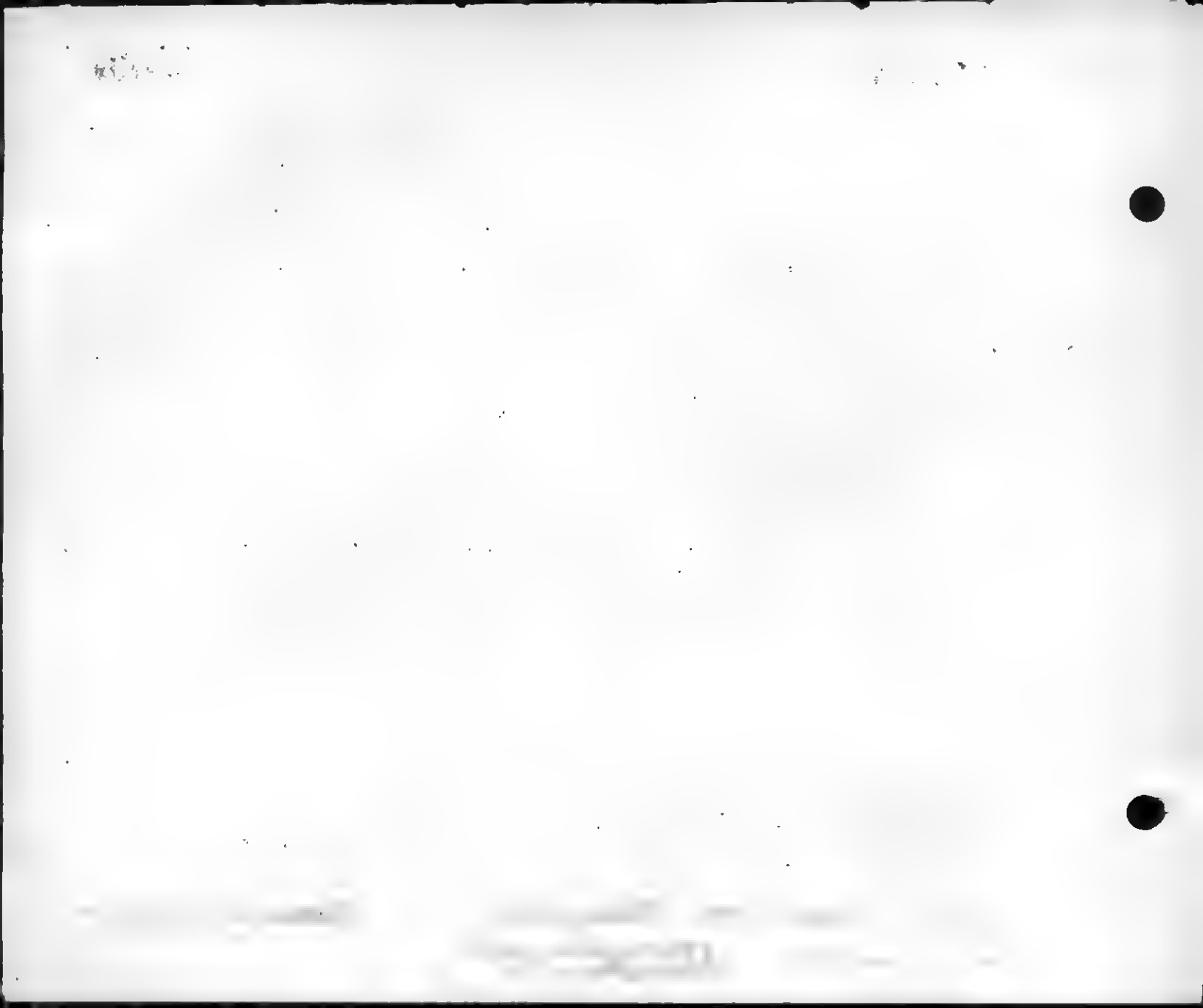
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07127

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07107

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i> ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Chesley</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Philadelph</i>	
c. LENGTH OF STAY IN ID <i>DOA</i>		d. STREET ADDRESS <i>5510 8th St. S. Green Hill Park</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Pr Geo General</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>WILLIAM ALLEN LEWIS</i>		4. DATE OF DEATH <i>May 20 19 47</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 10 1915</i> 51 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lawyer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Govt</i>	
11. BIRTHPLACE (State or foreign country) <i>Formfield NC</i>		12. COUNTRY OF WHAT CITIZENRY <i>USA</i>	
13. FATHER'S NAME <i>Benson</i>		14. MOTHER'S MAIDEN NAME <i>Dora Grody</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>214-14-0396</i>	
17. INFORMANT <i>Matty Renner</i>		Address <i>5008 Sitwell Hill</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> DUE TO (b) <i>arteriosclerotic heart disease</i> DUE TO (c) <i>hypertensive cardiovascular disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>19</i> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <i>Dayton O Watkins</i>		22. DATE SIGNED <i>5-21-47</i>	
EXAMINER'S NAME (Type) <i>DAYTON O WATKINS</i>		Address (Street, city, town, or county) <i>5318 Campbell Rd</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>May 23, 1947</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Valley View</i>	23d. LOCATION (City, town or county) (State) <i>Notkewille, Virginia</i>
24. FUNERAL DIRECTOR <i>Chesley Funeral Home</i>		25a. MAILED BY REGISTRAR <i>MAY 23 1947</i> 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



7 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 8, clm. 389 5/25/67 kk

07128

CERTIFICATE OF DEATH

07108

1 PLACE OF DEATH a COUNTY <u>Prince Georges</u> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>✓</u>		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u>		c LENGTH OF STAY IN b <u>4 months</u>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft Lauderdale</u> <u>11-1-67</u>		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Regent Hrs. + Rehabilitation Center</u>			d STREET ADDRESS <u>639 Middle River Drive</u>		e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <u>Alexander</u> Middle <u>Licariene</u> Last <u>Licariene</u>			4 DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1967</u>		
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 19, 1888</u>	9 AGE (In years last birth day) <u>86</u> yrs	IF UNDER 1 YEAR Months <u>5</u> Days <u>20</u> Hours <u>14</u> Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy Yard</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>	
13 FATHER'S NAME <u>Sacinto Licariene</u>			14 MOTHER'S MAIDEN NAME <u>Margaret Glass</u>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>		16 SOCIAL SECURITY NO <u>225-64-6487</u>		17 INFORMANT <u>Wynon Licariene 7411 Lacey St. Bethesda, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153.8 circulatory collapse</u> DUE TO (b) <u>Metastatic Carcinoma of Liver</u> DUE TO (c) <u>Cholera</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					INTERVA. BETWEEN ONSET AND DEATH <u>5-18-67</u> <u>5-20-67</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>5-3-67</u> to <u>5-20-67</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>5-20-67</u> at <u>1:30 PM</u> , and that death occurred <u>1:30 PM</u> , from causes and on the date stated above.					
22a SIGNATURE <u>W. H. H. McCoy MD</u>			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <u>5-20-67</u>	
22c PHYSICIAN'S NAME (Type) <u>Mark H. Pillor MD</u>			22d ADDRESS <u>6400 Marlboro Pike SE Washington</u>		
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or town) (County) (State)		
<u>Burial</u>	<u>5/24/1967</u>	<u>Wash. Nat'l</u>	<u>Washington, D.C.</u>		
24a FUNERAL DIRECTOR <u>W. H. H. McCoy</u>		24b ADDRESS <u>131-11th St. SE D.C.</u>		25a REC'D BY REGISTRAR <u>MAY 23 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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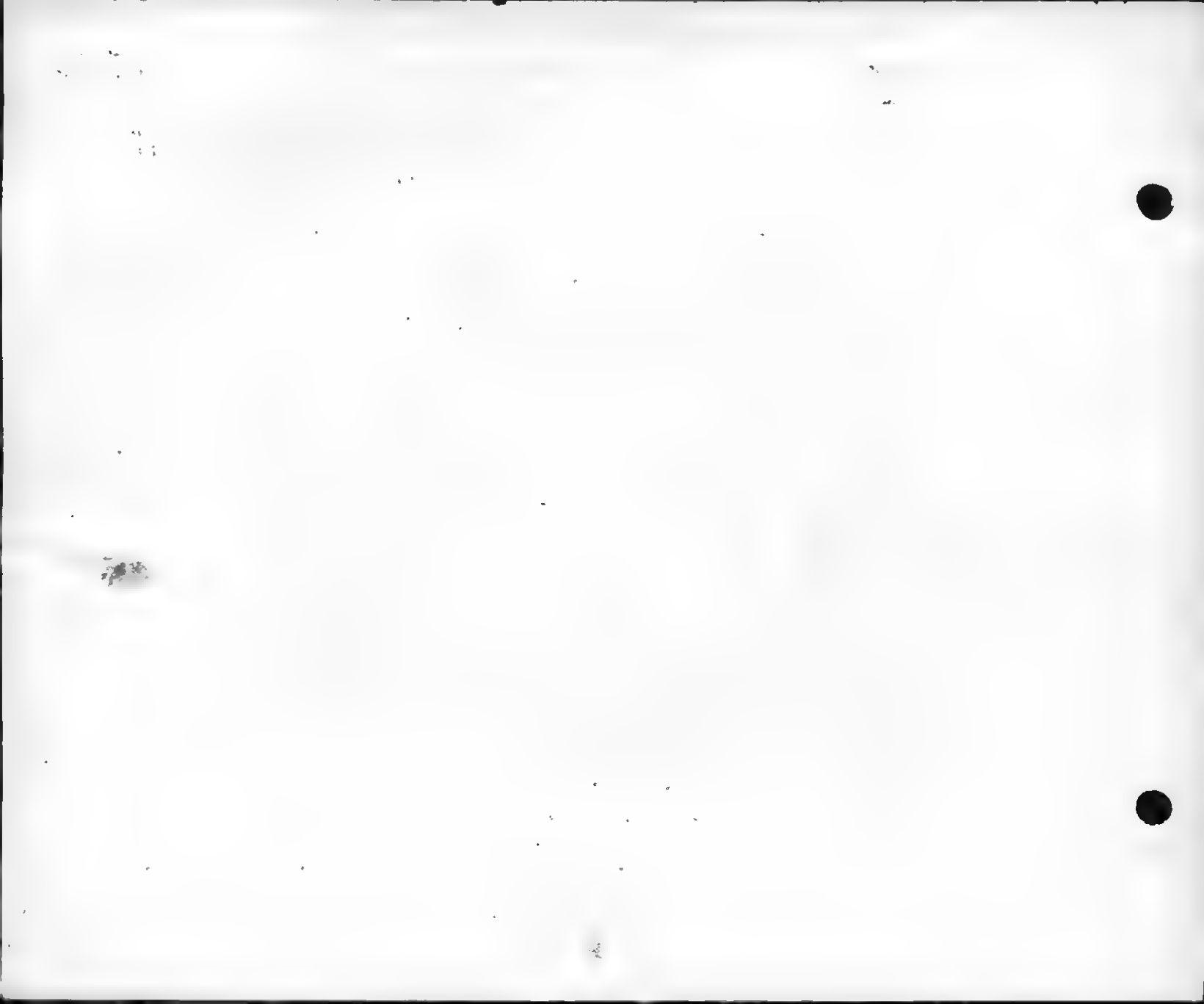
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07123

CERTIFICATE OF DEATH

07109

1 PLACE OF DEATH a COUNTY Prince Georges MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 16 hours		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d STREET ADDRESS 7405 Tilden St.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Doris M. Lilly				4 DATE OF DEATH Month Day Year May 16 1967			
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11/20/29		9 AGE (In years last birthday) 37 yrs	10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY own home		11 BIRTHPLACE (County & State, or foreign country) Penna		12 CITIZEN OF WHAT COUNTRY? U S A	
13 FATHER'S NAME Frank A Werner				14 MOTHER'S MAIDEN NAME Martha D Hicks			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO		17. INFORMANT Clarence B Lilly Address Hyattsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Scleroderma 7100 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						INTERVAL BETWEEN ONSET AND DEATH 6 years	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from June 1956 , to May 16, 1967 , that (I) (we) last saw the deceased alive on May 16, 1967 , and that death occurred at 9 A.M. from causes and on the date stated above.							
22a. SIGNATURE William D. Rosson M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) William D. Rosson, M. D.				22d. ADDRESS 5701 - 85th Ave. Hyattsville, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF May 19, 1967		23c NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d LOCATION (City or town) (County) (State) Colmar Manor Pro Geo Md.	
24 FUNERAL DIRECTOR F. Gasch's Sons Hyattsville Md.				25a REC'D BY REGISTRAR MAY 18 1967		25b REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

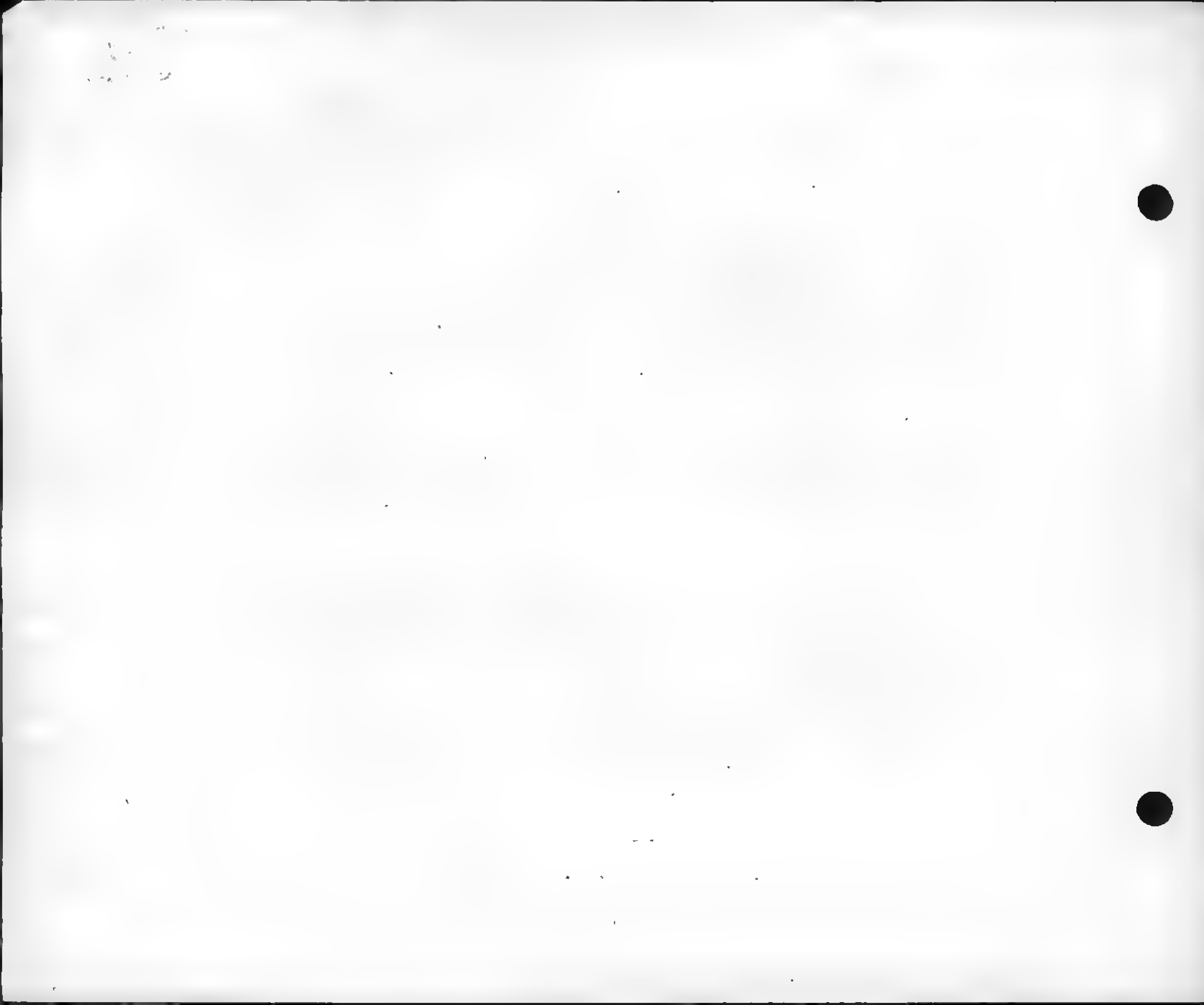
07130

07110

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN lb <u>12 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alice L Lohr</u>		4. DATE OF DEATH Month Day Year <u>May 16 19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1 Feb., 1894</u>
9. AGE (In years last birthday) <u>73</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>FRANK E. PYWELL</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE WEITZEL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>ARTHUR J. LOHR</u>		Address <u>SAME AS #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Adenocarcinoma, colon</u> <u>152.8</u> DUE TO (b) <u>Cerebrovascular accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <u>May 7, 1967</u> to <u>May 16, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 16, 1967</u> , and that death occurred at <u>1:50 PM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Donald W. Mitchell</u>		22b. DATE SIGNED <u>5/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Donald W. Mitchell, M.D.</u>		22d. ADDRESS <u>1746 K ST NW WASH DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5-20-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GEDAR HILL CEM</u>	23d. LOCATION (City or Town) (County) (State) <u>SUITLAND, MARYLAND</u>
24. FUNERAL DIRECTOR <u>W.W. Chambers</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAY 22 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

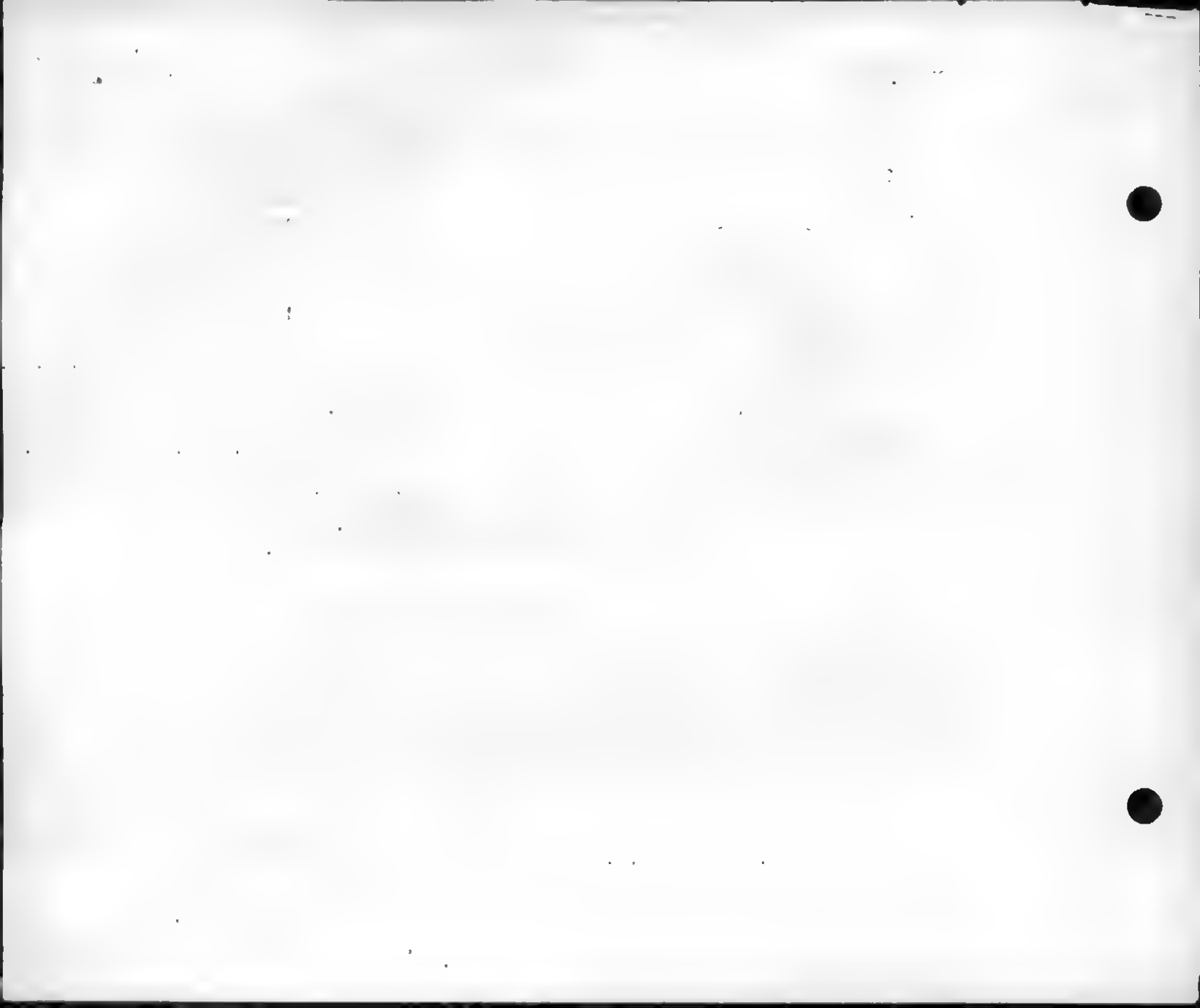
Item #9 Film #G389 6/6/67 pc

07131

CERTIFICATE OF DEATH

07111

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN IB 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 1139 49th Avenue	
3. NAME OF DECEASED (Type or print) First John Middle Alvin Last Long		4. DATE OF DEATH Month May Day 19 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 10, 1916
9. AGE (In years last birthday) 50 50 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Painter	
11. BIRTHPLACE (County & State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Fred L. Long		14. MOTHER'S MAIDEN NAME Susie P. Waller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 18	
17. INFORMANT John M. Long		Address 1130 49th. Ave. Hillside Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute bacterial endocarditis aortic valve 1300 DUE TO with perforation of aortic cusp. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bilateral bronchial pneumonia, severe. DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from May 17 , 19 67 , to May 19 , 19 67 , that (1) (we) last saw the deceased alive on May 19 , 19 67 , and that death occurred at 4:05 M , from causes and on the date stated above.			
22a. SIGNATURE Edwin J. Jensen		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED May 20, 1967
22c. PHYSICIAN'S NAME (Type) Edwin J. Jensen, M.D.		22d. ADDRESS Prince George's General Hospital Cheverly, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 23, 1967	23c. NAME OF CEMETERY OR CREMATORY Wash. National Cem.	23d. LOCATION (City or town) (County) (State) Suitland, Md.
24. FUNERAL DIRECTOR Robert E. Wilhelm Fun. Home		25a. REGISTERED BY REGISTRAR MAY 24 1967	25b. REGISTRAR'S SIGNATURE Charles Jones



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

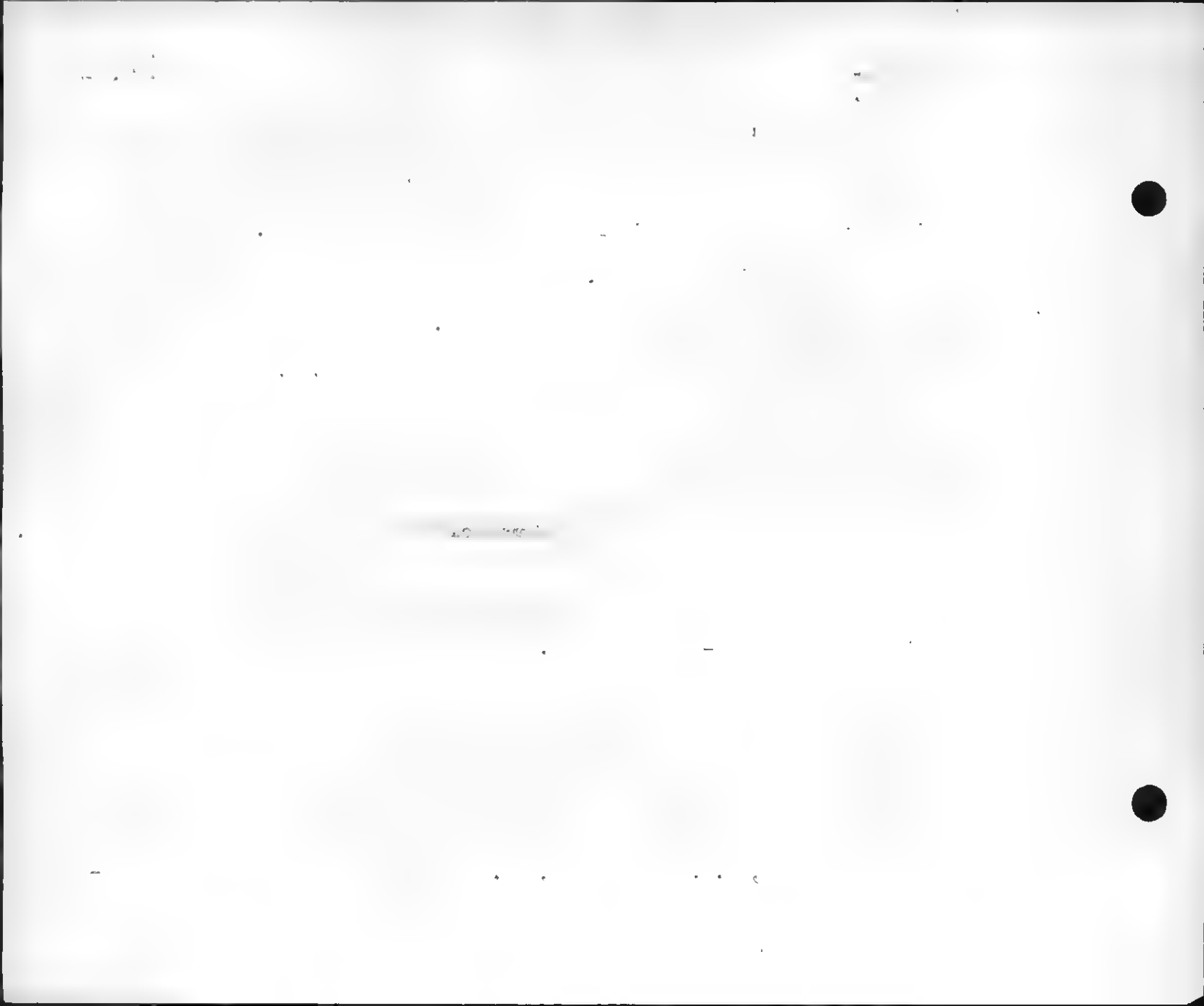
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07132

07112

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN TB DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 7615 Gateway Blvd.	
3 NAME OF DECEASED (Type or print) First Middle Last Mamie J. Mack		4 DATE OF DEATH Month Day Year 5 23 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2 Nov. 1890
9 AGE (In years last birthday) 76		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Washington D. C.	
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME Thaddues Alsop	
14 MOTHER'S MAIDEN NAME Catherine Frank		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO		17 INFORMANT Harold V. Mack Address Same As # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Hypertensive arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus - over 5 years.			INTERVAL BETWEEN ONSET AND DEATH minutes over 8 yrs.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town, County, State)
21. I certify that I took charge of the remains described above and an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D. M.D.		22. DATE SIGNED 5-24-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street, city, town, or county) Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/26/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or town, County, State) Prince Georges, Maryland
24. FUNERAL DIRECTOR Robert E. Wilhelm ADDRESS Funeral Home		25a. REC'D BY REGISTRAR MAY 29 1967	
4308 Suitland Road, Suitland, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07113

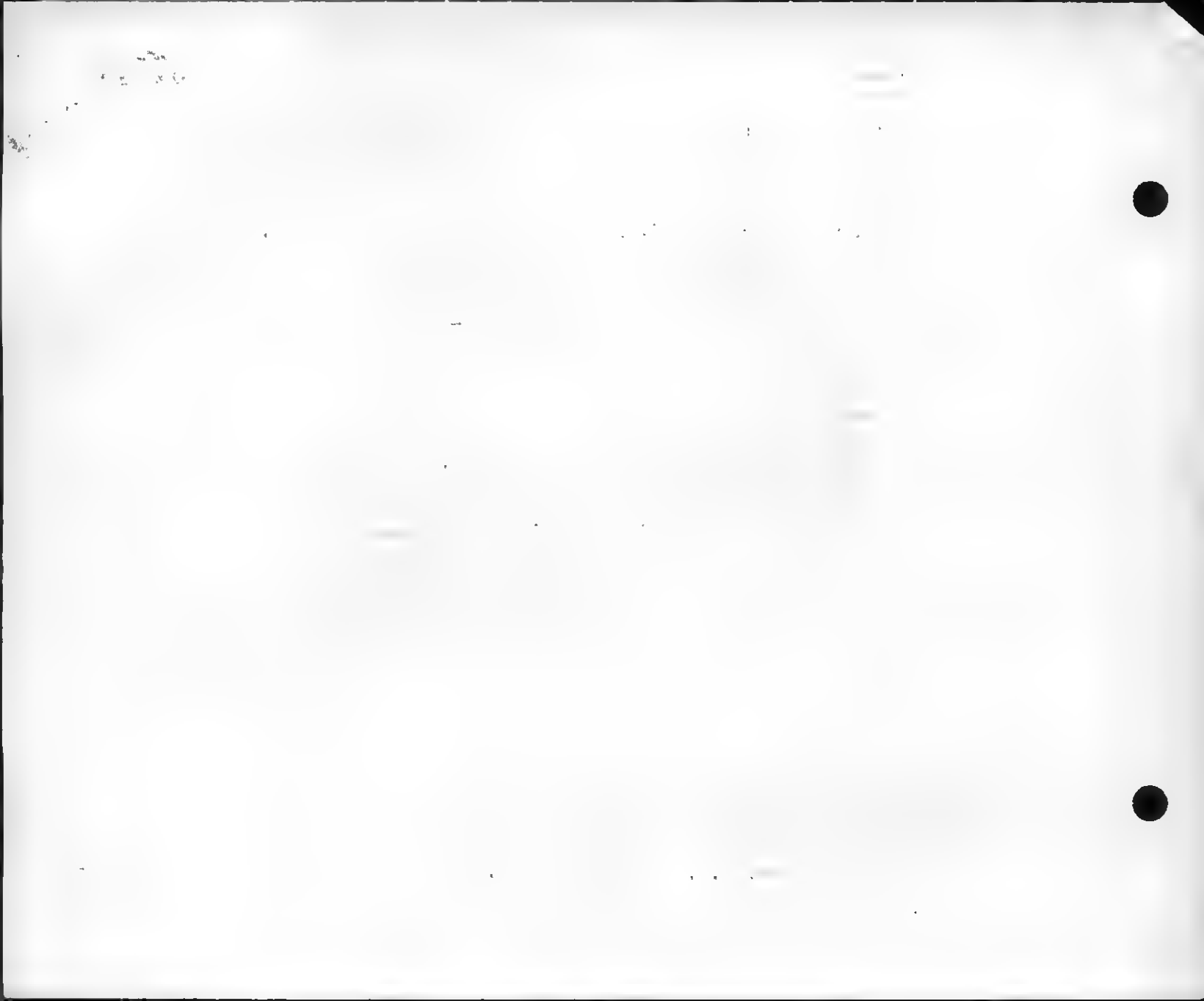
FOR STATE
HEALTH DEPT.

07133

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN TB DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address) Prince George General Hospital		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Marion Madsen		4 DATE OF DEATH 5 29 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3-5-1896
9 AGE (In years lost birthday) 71 yrs		10a USUAL OCCUPATION (Give kind of work done during most of work, no file, even if retired) Housewife	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Czechoslovakia	
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME Unknown	
14 MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16 SOCIAL SECURITY NO.		17. INFORMANT Crist L. Madsen Same As # 2	
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH minutes unknown	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accidents <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 5-31-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street city, town or county)	
23a BURIAL CREMATION REMOVAL (Specify)	23b DATE THEREOF 6/1/67	23c NAME OF CEMETERY OR CREMATORY Washington National	23d LOCATION (City or town) (County) (State) Prince Georges, Maryland
24 FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home		25a REC'D BY REGISTRAR JUN 5 1967	
4308 Suitland Road, Suitland, Maryland		25b REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

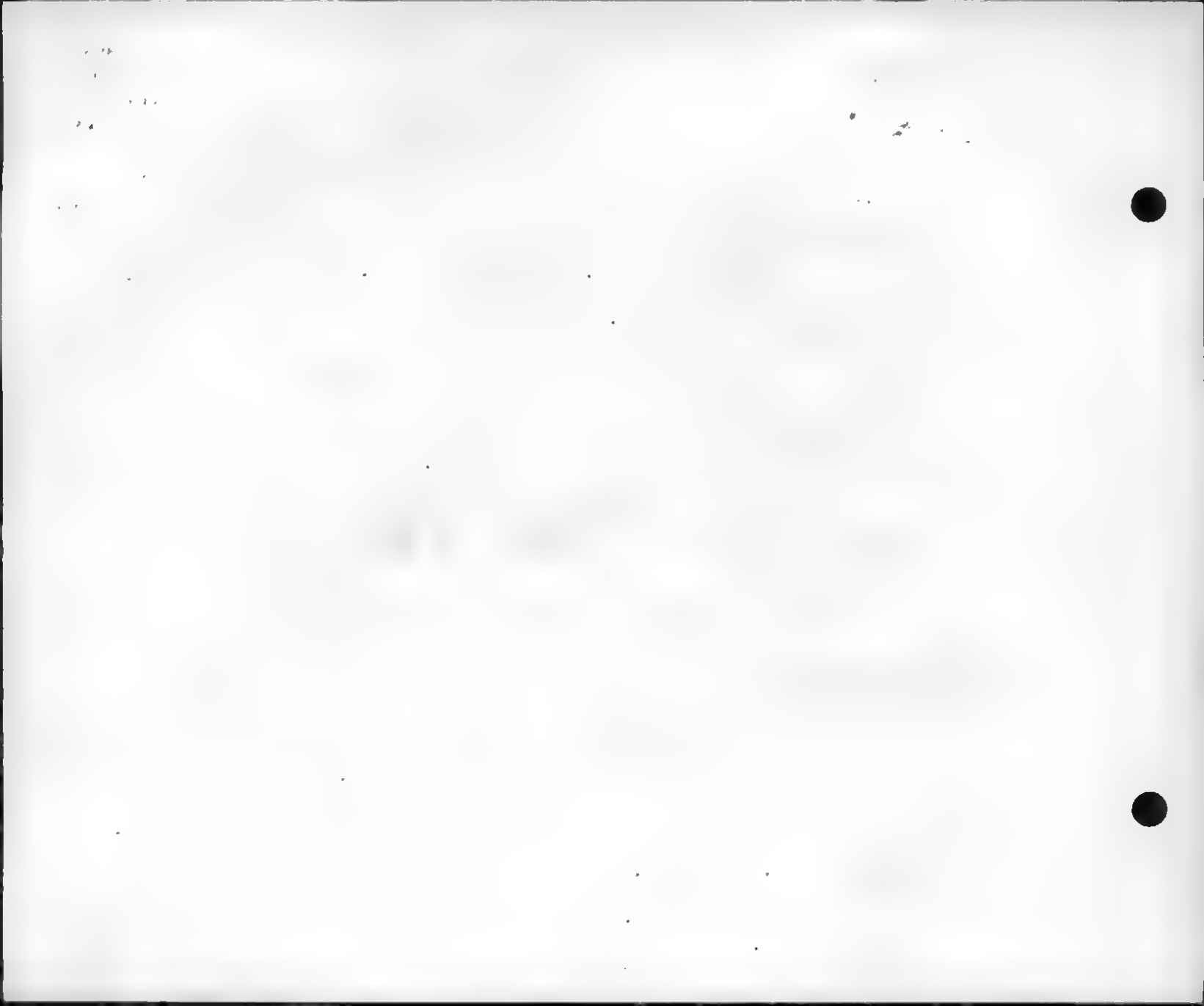
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07134

CERTIFICATE OF DEATH

07114

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 9 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 4929 Temple Hill Road			
3 NAME OF DECEASED (Type or print) First Middle Last Samuel ALFRED Marquis JR.				4 DATE OF DEATH Month Day Year May 4, 1967			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH March 15, 1907	9. AGE (in years last birthday) 60 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11 BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SAMUEL A. MARQUIS				14. MOTHER'S M.A.DEN NAME BERTHA LANLEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO		17. INFORMANT Address THELMA L. MARQUIS SAME AS # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____ DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last _____ (b) _____ DUE TO _____ (c) _____ Hepatic Failure Portal Cirrhosis						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from April 25, 1967 , to May 4, 1967 , that it (we) last saw the deceased alive on May 4, 1967 , and that death occurred at 12:15M , from causes and on the date stated above							
22a. SIGNATURE Edwin Jensen				22b. DATE SIGNED May 4, 1967		22c. PHYSICIAN'S NAME (Type) Edwin I. Jensen, M.D.	
22d. ADDRESS Prince Georges General Hospital							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/8/67		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		23d. LOCATION (City or Town) (County) (State) PARKERSBURG, WEST VIRGINIA	
24. FUNERAL DIRECTOR ROBERT E. WILHELM FUNERAL HOME 4308 SUTLAND ROAD, SUTLAND, MARYLAND				25a. REC'D BY REGISTRAR MAY 8 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07135

CERTIFICATE OF DEATH

07115

1. PLACE OF DEATH a. COUNTY Prince Georges		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN TB 13 days		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital	
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		d. STREET ADDRESS 219-D PFD #2	
3. NAME OF DECEASED (Type or print) John F. Marsh		4. DATE OF DEATH May 22 1967		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 7/29/22		9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer (mechanical self-employed)		10b. KIND OF BUSINESS OR INDUSTRY self-employed		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Vernon H. Marsh		14. MOTHER'S MAIDEN NAME Bettye Davis		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. [redacted]	
17. INFORMANT Ruth Marsh		18. ADDRESS [redacted]		19. WAS ALTPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro-intestinal Hemorrhage secondary to ruptured esophageal varices. DUE TO (b) Hepatic insufficiency, secondary to (c) billiary cirrhosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) [redacted]							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the doctor) attended the deceased from 5/9 to 5/22, 1967, that (I) last saw the deceased alive on 5/22, 1967, and that death occurred at 11:30, from the causes and on the date stated above.							
22a. SIGNATURE [Signature]		22b. DATE SIGNED 5/22/67		22c. PHYSICIAN'S NAME (Type) Norman J. Comenau		22d. ADDRESS 3503 Pennyst Mt Prince Md	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 5/25/67		23c. NAME OF CEMETERY OR CREMATORY 1st Lincoln		23d. LOCATION (City, town or county) (State) Colman Manor Md.	
24. FUNERAL DIRECTOR'S SIGNATURE [Signature]		25a. REC'D BY REGISTRAR DATE MAY 29 1967		25b. REGISTRAR'S SIGNATURE [Signature]			

100



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07136

07116

1 PLACE OF DEATH a. COUNTY <u>Pr. George</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Pr. George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltville</u>				c. LENGTH OF STAY IN 1b <u>16 yr</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4932 Powder Mill Rd</u>				d. STREET ADDRESS <u>4932 Powder Mill Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) <u>Dallas James Marvel</u>				4. DATE OF DEATH <u>May 29 1967</u>			
5 SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 11, 1890</u>	
9 AGE (In years last birthday) <u>76</u> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Decorator Painter Building</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>James F. Marvel</u>				14. MOTHER'S MAIDEN NAME <u>Clara Belle Beach</u>			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <u>Yes 1918-1919</u>				16. SOCIAL SECURITY NO. <u>216-05-8564</u>			
17. INFORMANT <u>Mrs Grace Marvel</u>				Address (Wife) <u>Same as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes Mellitus</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>9 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>N/A</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>5/20</u> , 19 <u>67</u> , to <u>5/29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/29</u> , 19 <u>67</u> , and that death occurred at <u>2 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert S. McCeney</u>				22b. DATE SIGNED <u>5/29/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert S. McCeney, M.D.</u>				22d. ADDRESS <u>ROBERT S. MCCENEY, M. D. 402 MAIN ST. LAUREL, MARYLAND 20810</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 1, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Laurel, Delaware</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>				25a. REC'D BY REGISTRAR <u>JUN 1 1967</u>			
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

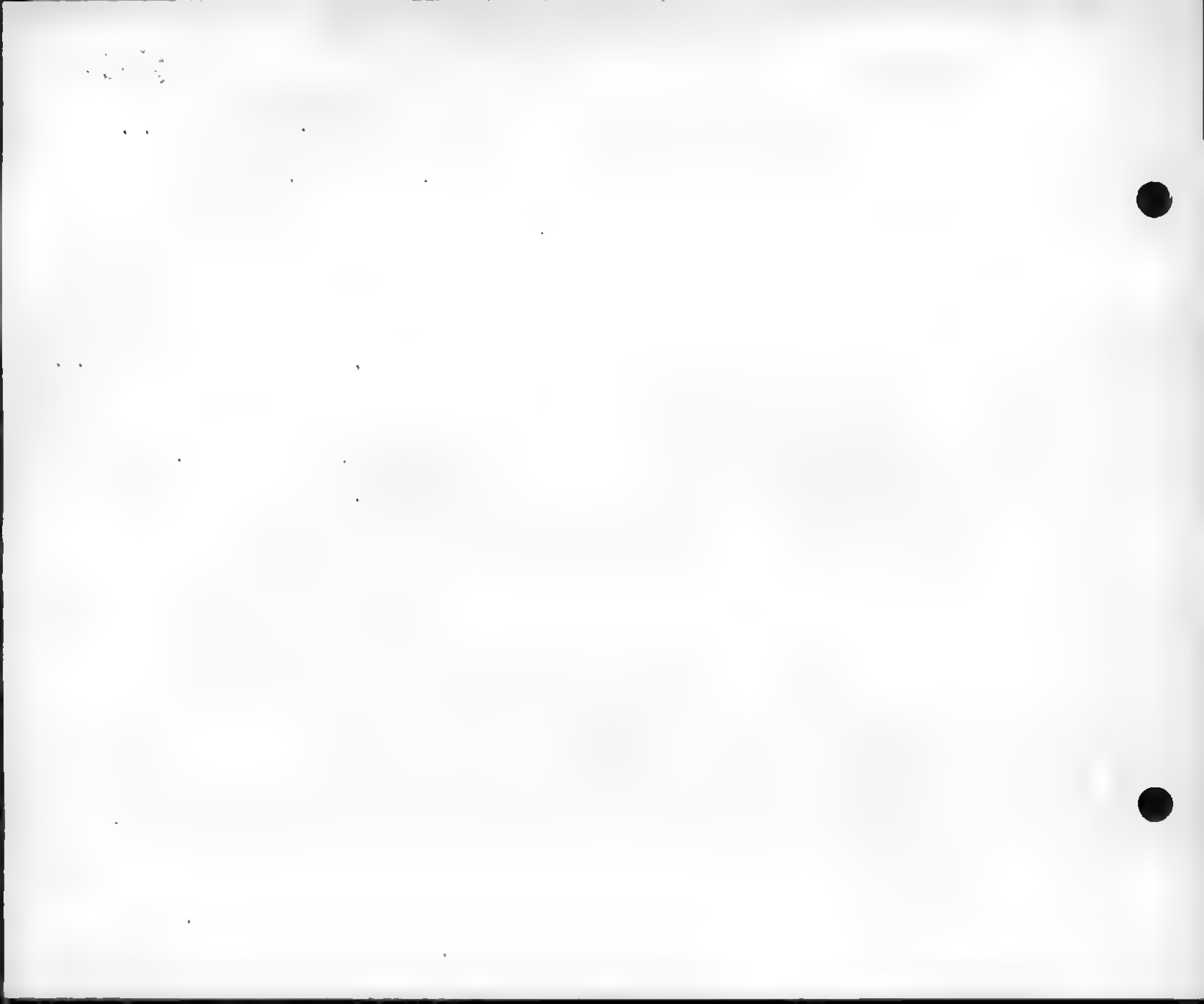
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #0 Film #G-4-1-157 DC

07137

CERTIFICATE OF DEATH

07117

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			c. LENGTH OF STAY IN 1b <u>Three mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CATROLL MANOR 4922 LASALLE</u>				d. STREET ADDRESS <u>2440 101st St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>CECILIA</u> Last <u>MASON</u>				4. DATE OF DEATH Month <u>10</u> Day <u>12</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/12/1891</u>	9. AGE (In years last birthday) <u>73</u> yrs	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Cal. U.S.</u>		
13. FATHER'S NAME <u>Patrick O' Connor</u>				14. MOTHER'S MAIDEN NAME <u>Mary Burke</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>10</u>		17. INFORMANT <u>Thomas F. Collins</u> Address <u>322 H St</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARCINOMA OF BOWEL</u> DUE TO (b) <u>with generalized metastases</u> DUE TO (c) <u>lost</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2-4 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>April 5, 1961</u> to <u>May 1, 1961</u> , that (I) (we) last saw the deceased alive on <u>MAY 1, 1961</u> , and that death occurred at <u>5 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Thomas F. Collins</u>			M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>5-1-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>THOMAS F. COLLINS</u>			22d. ADDRESS <u>322-H ST NE</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>		23b. DATE THEREOF <u>5/1/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, MD</u>	
24. FUNERAL DIRECTOR <u>Interiors & Son Funeral Home</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07138

CERTIFICATE OF DEATH

07118

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUITLAND</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUITLAND Nursing Home</u>				d. STREET ADDRESS <u>5410 Border Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOSEPH A MASSINO</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 26, 1887</u>	9. AGE (In years last birthday) <u>79</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Frame Fitter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Angelo Massino</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Columbia</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Frank A. Tubia-nephew Same as #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 1, 1967</u> , to <u>May 2, 1967</u> that (I) (we) last saw the deceased alive on <u>March 1, 1967</u> , and that death occurred at <u>9:30 p.m.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Frank S. Pellegrini</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>J. 2. 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK S. PELLEGRINI</u>				22d. ADDRESS <u>3611 BRANCH AVE SE</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-6-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>Lee Funeral Home 300 4th St. N.E. Wash. D.C.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Coroner Notified

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

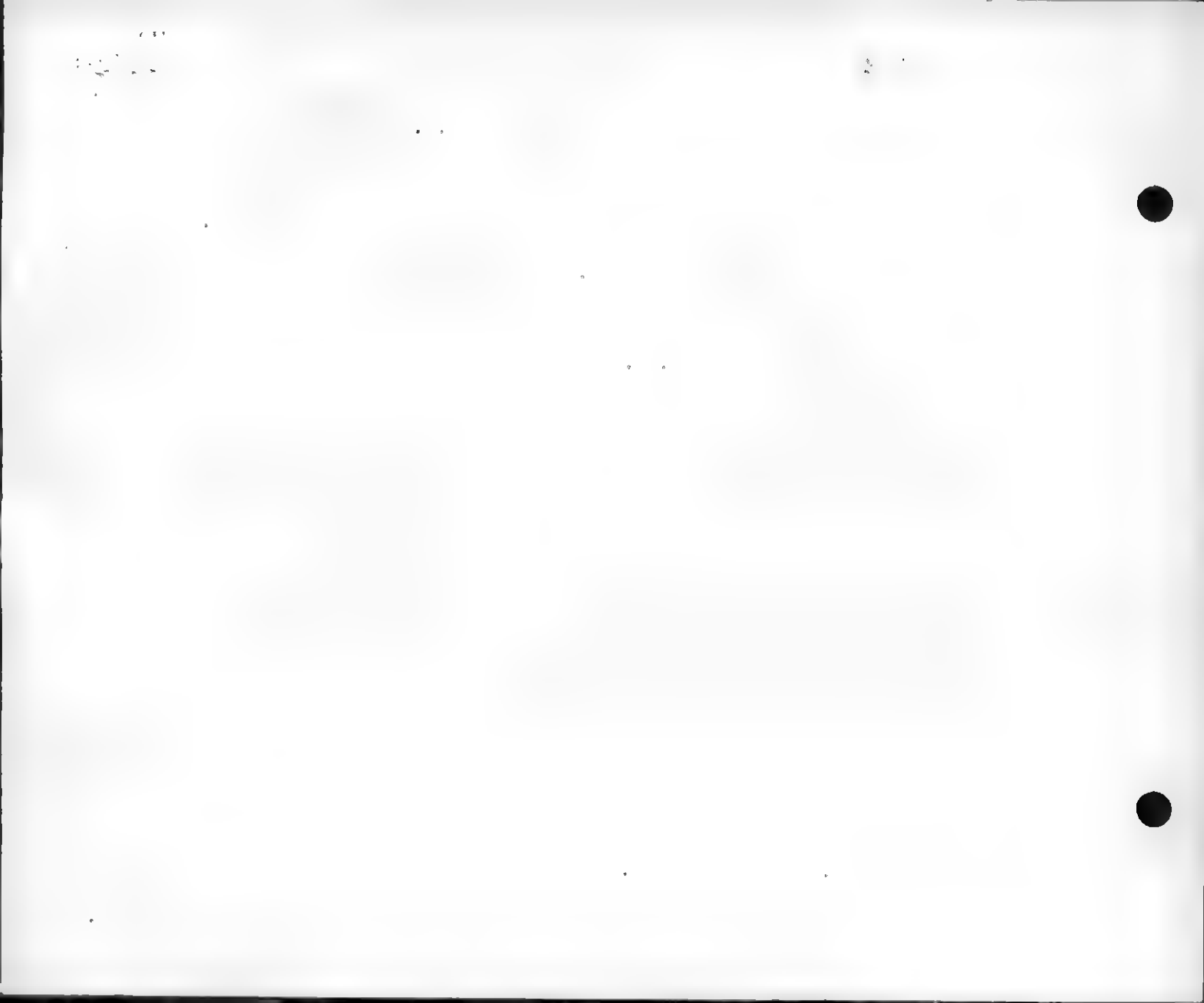
07139

CERTIFICATE OF DEATH

07119

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital				d. STREET ADDRESS 1808 Benning Rd., N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last George B. Matthews				4. DATE OF DEATH Month Day Year 5 18 19 67			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1-1-22	
9. AGE (In years last birthday) 45 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Bernard Matthews				14. MOTHER'S MAIDEN NAME Margaret Jackson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Sister and Medical Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 3 XIX CEREbrovascular ACCIDENT DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH 11 DAYS
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HEPATIC FAILURE							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-6-67, 19, to 5-18-67, 19, that (I) (we) last saw the deceased alive on 5-17 1967, and that death occurred at 8:35 AM, from causes and on the date stated above							
22a. SIGNATURE C. J. Houmann				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-18-67	
22c. PHYSICIAN'S NAME (Type) C. J. Houmann, M.D.				22d. ADDRESS 4404 Queensbury Rd., Riverdale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/22/67		23c. NAME OF CEMETERY OR CREMATORY CARVER MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) LAUREL, PRINCE G. MD	
24. FUNERAL DIRECTOR George R. Anderson				25a. REC'D BY REGISTRAR Rockwell		25b. REGISTRAR'S SIGNATURE Charles Jones	

MAY 24 1967



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

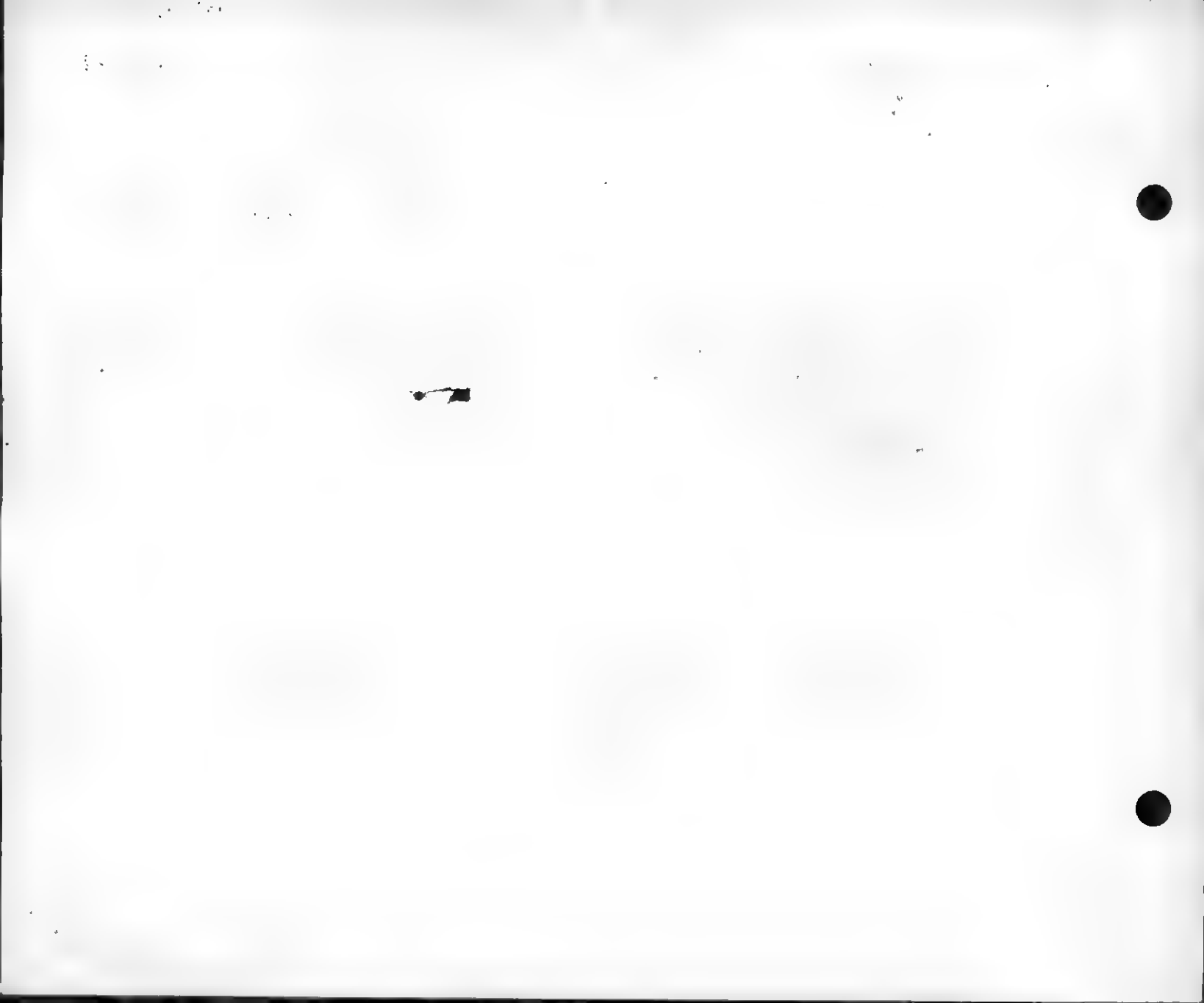
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07140

CERTIFICATE OF DEATH

07120

1. PLACE OF DEATH a. COUNTY PG. Riverdale, MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Washington, DC. <input checked="" type="checkbox"/> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington,			
c. LENGTH OF STAY IN 1b 1 Day.				d. STREET ADDRESS 20 "E" Street N.W., Dodge Hotel			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Hospital.				e. IS RESIDENCE IN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edward Middle H Last McCrahon.				4. DATE OF DEATH Month May Day 2 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3-11-91		9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done, including most working hours of day) Superintendent Health Dept. Retired from DC. Government.				11. BIRTHPLACE (County & State, or foreign country) New York,		12. CITIZEN OF WHAT COUNTRY? Amer.	
13. FATHER'S NAME Alexander McCrahon				14. MOTHER'S MAIDEN NAME Mary Hughes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or not known. If yes, give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO. 579 03 1862		17. INFORMANT Eugene Leland Hospital, 4408 Queensbury Rd, Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) VENTRICULAR ARRYTHMIA & FIBR. 4201 DUE TO MYOCARDIAL INFARCTION, ACUTE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH ONE DAY ONE WEEK	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2 MAY, 1967, to 2 MAY, 1967, that (I) (we) last saw the deceased alive on 2 MAY 1967, and that death occurred at 6:15 PM, from causes and on the date stated above.							
22a. SIGNATURE C. J. HOUHANN OK M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2 MAY 67	
22c. PHYSICIAN'S NAME (Type) C. J. HOUHANN DR. KETTER				22d. ADDRESS RIVERDALE MD			
23a. BURIAL, CREMATION, or other (Specify) Burial		23b. DATE THEREOF 5/8/67		23c. NAME OF CEMETERY OR CREMATORY Alexandria National		23d. LOCATION (City or Town) (County) (State) Alexandria Va.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE MAY 5 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

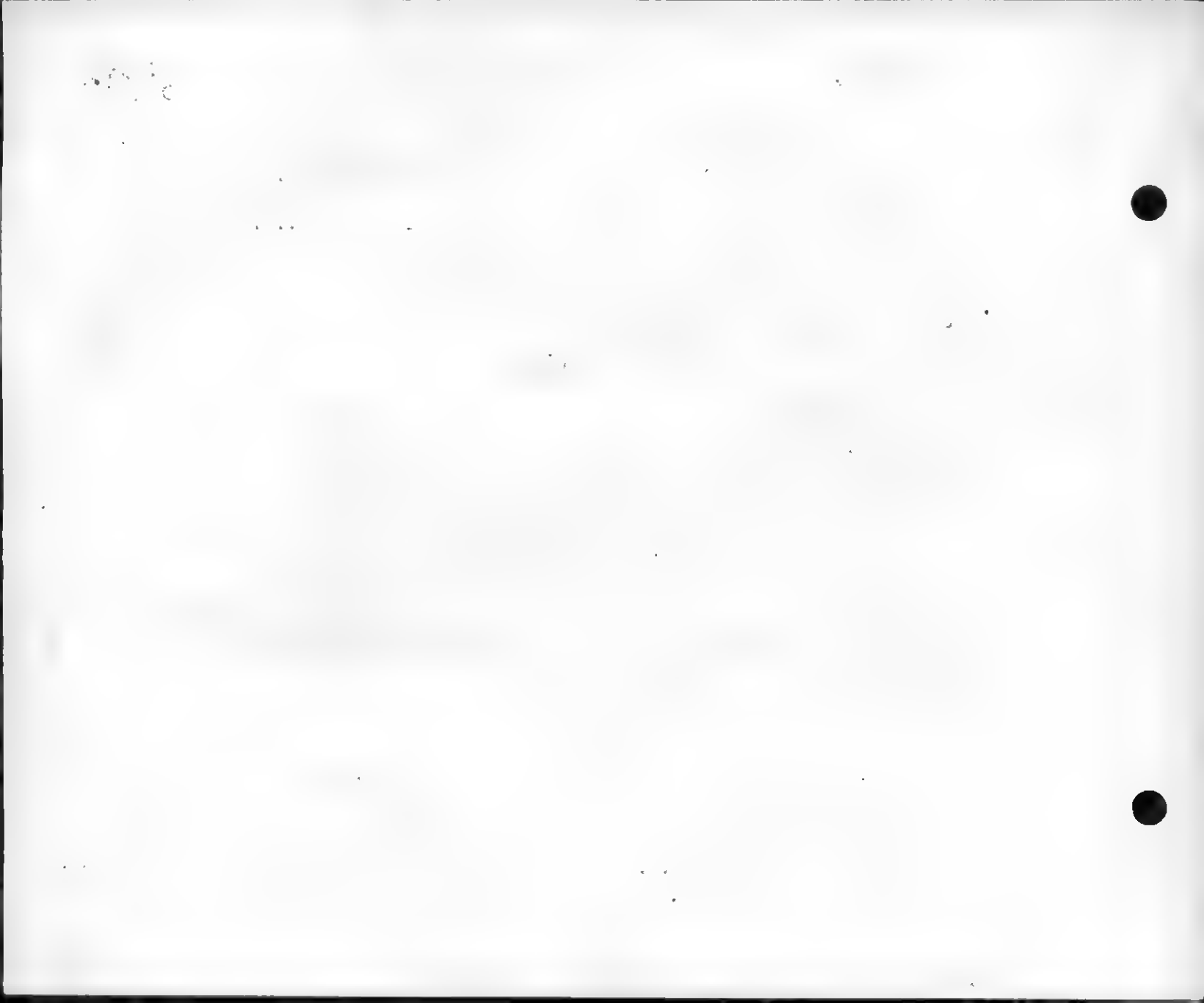
07141

07121

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D. C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. LENGTH OF STAY IN 1b 9 mo			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital				d. STREET ADDRESS 637 D St., S.E.			
3. NAME OF DECEASED (Type or print) First Gerald Middle J. Last McDonough				4. DATE OF DEATH Month May Day 25 Year 19 67			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8/28/1905	9. AGE (in years last birthday) 61 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0		11. IF UNDER 24 HRS. Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salesman			10b. KIND OF BUSINESS OR INDUSTRY furniture co. UNKNOWN		11. BIRTHPLACE (County & State, or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Thomas McDonough				14. MOTHER'S MAIDEN NAME Bertha Elbrecht			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 577-12-6787		17. INFORMANT decedent Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive gastrointestinal hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of the liver with duodenal ulcer and esophageal varices DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) Chronic alcoholism with chronic brain syndrome and peripheral neuropathy; osteomyelitis rt. foot; replacement of lower aorta, abdominal aorta & iliac*							INTERVAL BETWEEN ONSET AND DEATH 30 min. 2 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from 9/1/1966 , to 5/25/1967 , that (X) (we) last saw the deceased alive on 5/25/1967 , and that death occurred at 8:20 P.M. , from causes and on the date stated above.							
22a. SIGNATURE Moe Weiss				22b. DATE SIGNED 5/25/67		22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.	
22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.				22e. MED. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 29, 1967		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION (City or town) (County) (State) SUITLAND, MARYLAND	
24. FUNERAL DIRECTOR Chamberlain & Sons		25a. REC'D BY REGISTRAR MAY 29 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION
arteries by nylon graft 1961; coronary arteriosclerosis.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

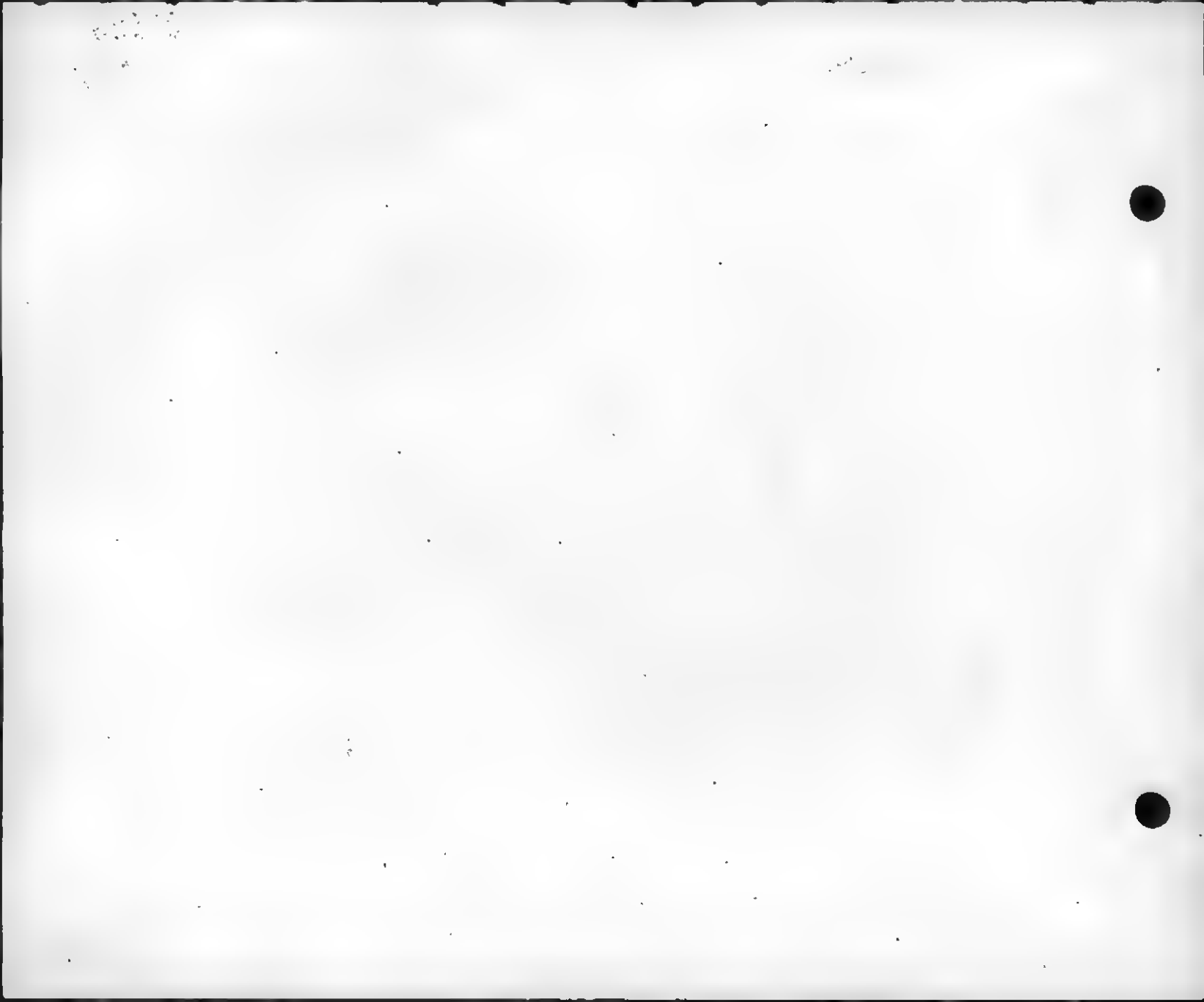


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
07142 CERTIFICATE OF DEATH 07122

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MARYLAND c. COUNTY PRINCE GEORGE			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) COLLEGE PARK				c. LENGTH OF STAY IN 1b 60 YRS			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9014 RHODE ISLAND AVE				d. STREET ADDRESS 9014 RHODE ISLAND AVE			
3. NAME OF DECEASED (Type or print) First MARY Middle ESTHER Last MCINTYRE				4. DATE OF DEATH Month MAY Day 17 Year 1967			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 24 1899	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUDITOR		10b. KIND OF BUSINESS OR INDUSTRY INFAGENCY U.S.G. WASHINGTON D.C.	
11. BIRTHPLACE (County & State, or foreign country) WASHINGTON D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME JOHN HENRY MCINTYRE		14. MOTHER'S MAIDEN NAME LORA ANNIE REYNOLDS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-44-8890		17. INFORMANT RUTH C. MCINTYRE		Address SAME AS #2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 44.5X Hypertensive Heart (b) Myocarditis (c) Cerebral apoplexy PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none							INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 4 yrs. 4 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ✓			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 11 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ✓		20f. (City or town) (County) (State) ✓	
21. I certify that (I) (this hospital) attended the deceased from 1960, to May 17, 1967, that (I) (we) last saw the deceased alive on May 17, 1967, and that death occurred at 109 M, from the causes and on the date stated above.							
22a. SIGNATURE N.B. STEWARD				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 18, 1967	
22c. PHYSICIAN'S NAME (Type) N.B. STEWARD M.D.				22d. ADDRESS LAUREL - MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF May 20 1967		23c. NAME OF CEMETERY OR CREMATORY Ft. LINCOLN CEM.		23d. LOCATION (City, town or county) (State) BLADENSBURG MARYLAND	
24. FUNERAL DIRECTOR ADDRESS W. W. CHAMBERS CO RIVERDALE, MARYLAND				25a. REC'D BY REGISTRAR DATE MAY 22 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07143

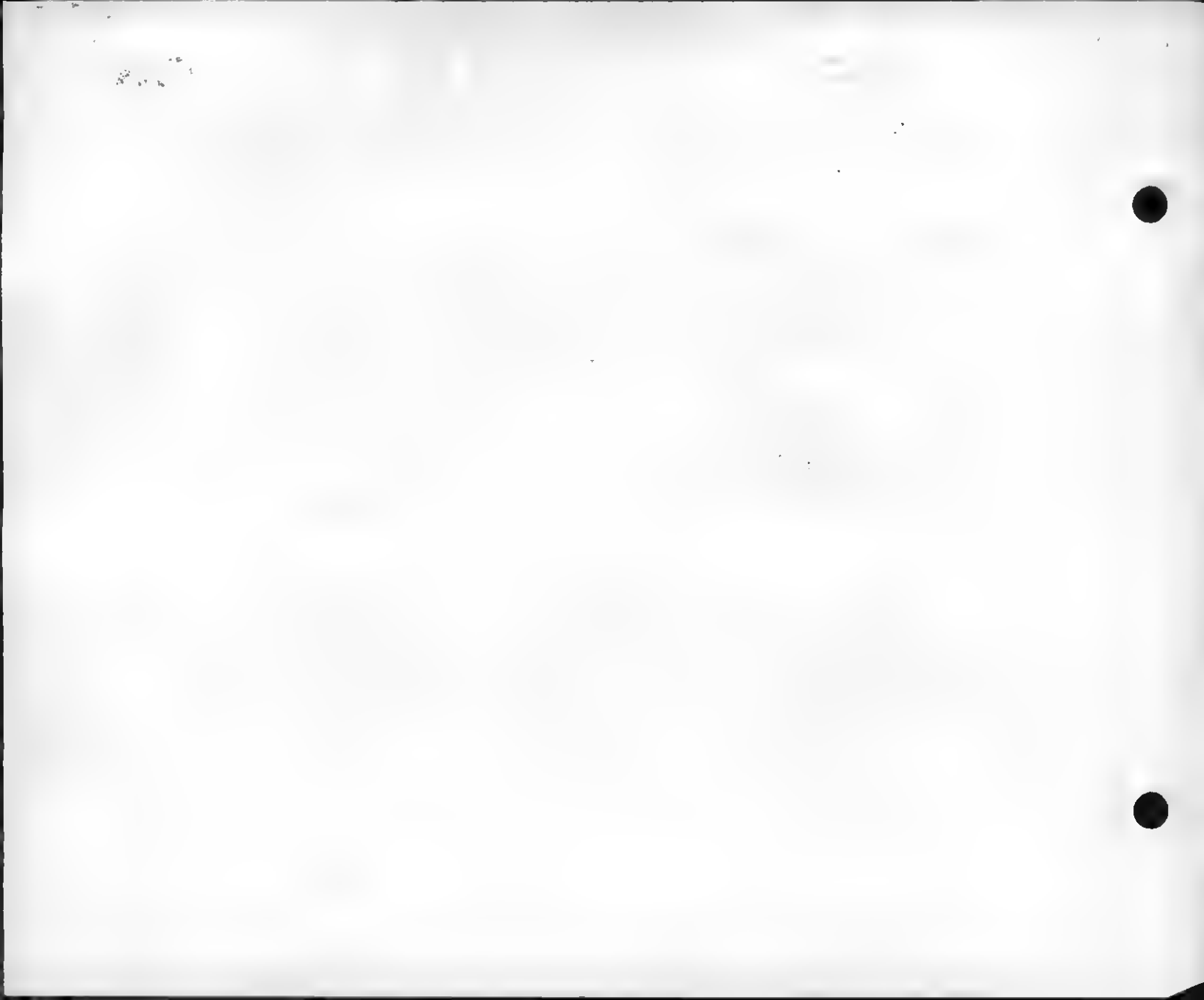
CERTIFICATE OF DEATH

07123

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY PRINCE GEORGES MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE NEW YORK b COUNTY ONEIDA	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB BASE		c LENGTH OF STAY in 1b 1 mo. 1 Day	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		d STREET ADDRESS 829 MILDRED AVENUE	
3 NAME OF DECEASED (Type or print) First Middle Last JOHN J MCSALLY		4 DATE OF DEATH Month Day Year MAY 28 1967	
5 SEX MALE	6 COLOR OR RACE CAU	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 29 JUN 33
9. AGE (In years lost birthday) 33 yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USAF		10b. KIND OF BUSINESS OR INDUSTRY USAF	
11. BIRTHPLACE (County & State, or foreign country) ONEIDA, NEW YORK		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPH J. MCSALLY		14 MOTHER'S MAIDEN NAME GERTRUDE MACCRACKEN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES 1953-1967		16. SOCIAL SECURITY NO. 095-20-9692	
17. INFORMANT MOTHER		Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1909 <u>CARDIAC-RESPIRATORY EMBARRASSMENT</u> DUE TO (b) <u>METASTATIC DISEASE</u> DUE TO (c) <u>MALIGNANT MELANOMA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (X) (this hospital) attended the deceased from 27 Apr, 1967, to 28 May, 1967, that (X) (we) last saw the deceased alive on 28 May, 1967, and that death occurred on 10:30 PM from causes and on the date stated above.			
22a. SIGNATURE <i>Dixon Yeste</i> M.D.		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22b. DATE SIGNED 28 May 1967
22c. PHYSICIAN'S NAME (Type) DIXON YESTE, CAPT USAF MC		22d. ADDRESS USAF Hospital Andrews Andrews AFB Wash Dc 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5-31-1967	23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) White Plains New York
24 FUNERAL DIRECTOR W.W. Chambers Co		25a. REC'D BY REGISTRAR DATE JUN 1 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

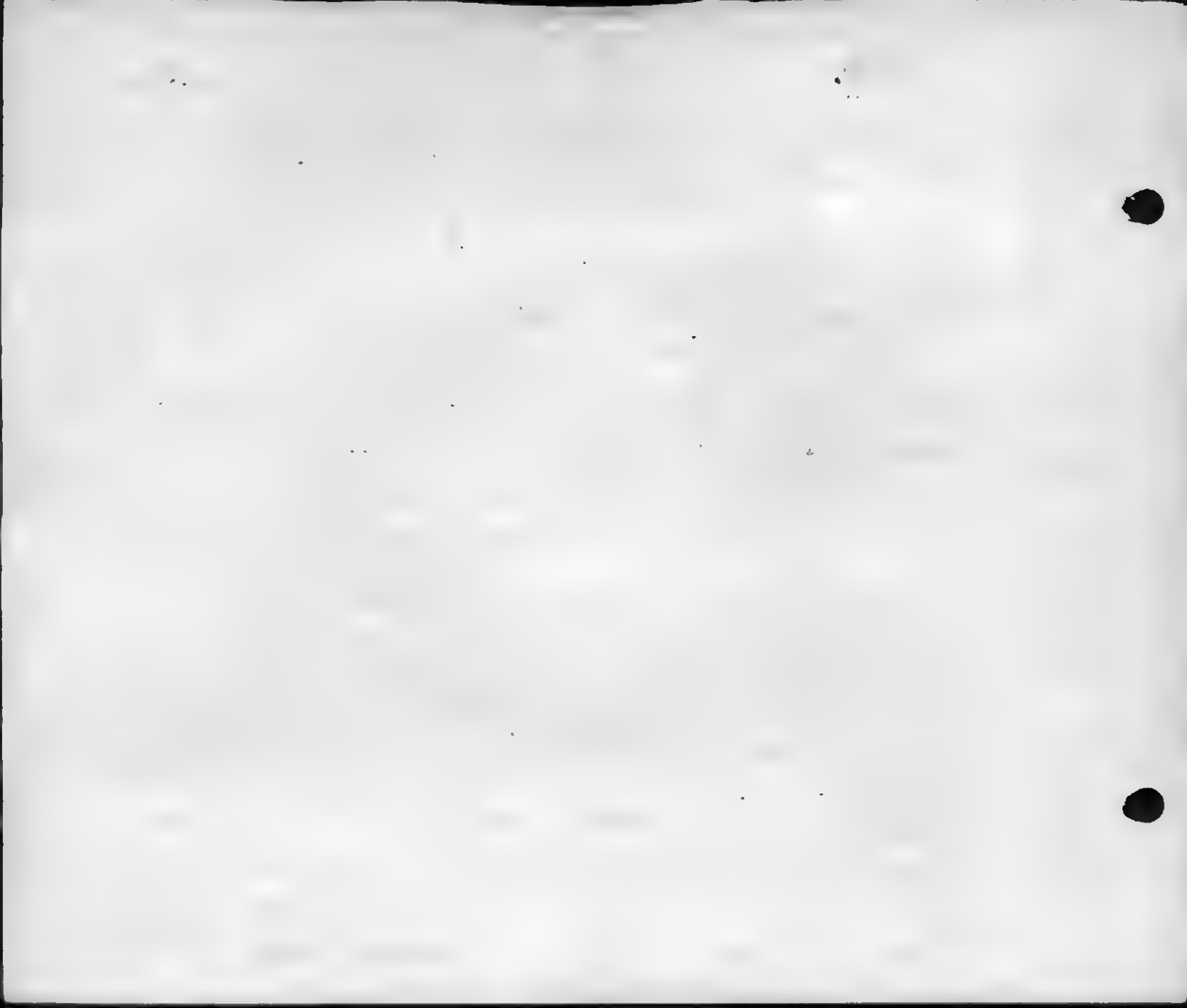
07144

07124

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if instit. on residence before admission) a. STATE MARYLAND b. COUNTY PR. GEO'S			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) College Park, Md.				c. LENGTH OF STAY IN b. 4 YRS			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 6904 Carleton Terrace			
				d. STREET ADDRESS College Park, Maryland			
3. NAME OF DECEASED (Type or print) STANLEY REYNOLDS McVEY				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX MALE				6. DATE OF BIRTH 8-29-77			
6. COLOR OR RACE W				7. MARIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 8-29-77				9. AGE (In years last birthday) 89 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING				10b. KIND OF BUSINESS OR INDUSTRY FARMER			
11. BIRTHPLACE (County & State, or foreign country) Cecil County, Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME BENJAMIN McVEY				14. MOTHER'S MAIDEN NAME MARGARET REYNOLDS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 67-076-963			
17. INFORMANT C.N.C. McVEY-6904 Carleton Terrace				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Cerebral Hemorrhage DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 HOUR 20 YRS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from MAR 17 1967 to MAY 9 1967 , that (I) (we) last saw the deceased alive on MAR 17 1967 , and that death occurred at 6 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Herbert H. Brandes M.D.				22b. DATE SIGNED MAY 9, 1967			
22c. PHYSICIAN'S NAME (Type) HERBERT BRANDES				22d. ADDRESS 3400 UNIV. BLVD E. Adelphi, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 5/11/67			
23c. NAME OF CEMETERY OR CREMATORY ROSEBANK CEM.				23d. LOCATION (City, town or county) (State) CALVERT, CECIL CO, MD			
24. FUNERAL DIRECTOR'S SIGNATURE RALPH M. REED Ralph M. Reed				25a. REC'D BY REGISTRAR RISING SUN, MD			
25b. REGISTRAR'S SIGNATURE Charles Judge				25c. DATE MAY 12 1967			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-100. 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07145

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07125

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 124 Mohican Drive	
3 NAME OF DECEASED (Type or print) First Anna Middle M. Last Miller		4 DATE OF DEATH Month 5 Day 7 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2 June 1884
9 AGE (In years last birthday) 82 yrs		10 UNDER 1 YEAR Months 19 Days 67	
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife		10b KIND OF BUSINESS OR INDUSTRY - - -	
11 BIRTHPLACE (State or foreign country) New York		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Unknown		14 MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) - - -		16 SOCIAL SECURITY NO - - -	
17 INFORMANT Forest Hills, Md.		Francis Miller-124 Mohican Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4300 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) - (c) -		INTERVAL BETWEEN ONSET AND DEATH minutes unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspect an <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D. M.D.		22. DATE SIGNED 5-8-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city town or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) Removal		23b DATE THEREOF 8-8-1967	
23c NAME OF CEMETERY OR CREMATORY St. Bonaventure Cem.		23d LOCATION (City or Town) (County) (State) Allegany N.Y.	
24 FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. ADDRESS 5130 Wisconsin Ave. N.W. Wash. D.C.		25a REC'D BY REGISTRAR DAV 10 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07146

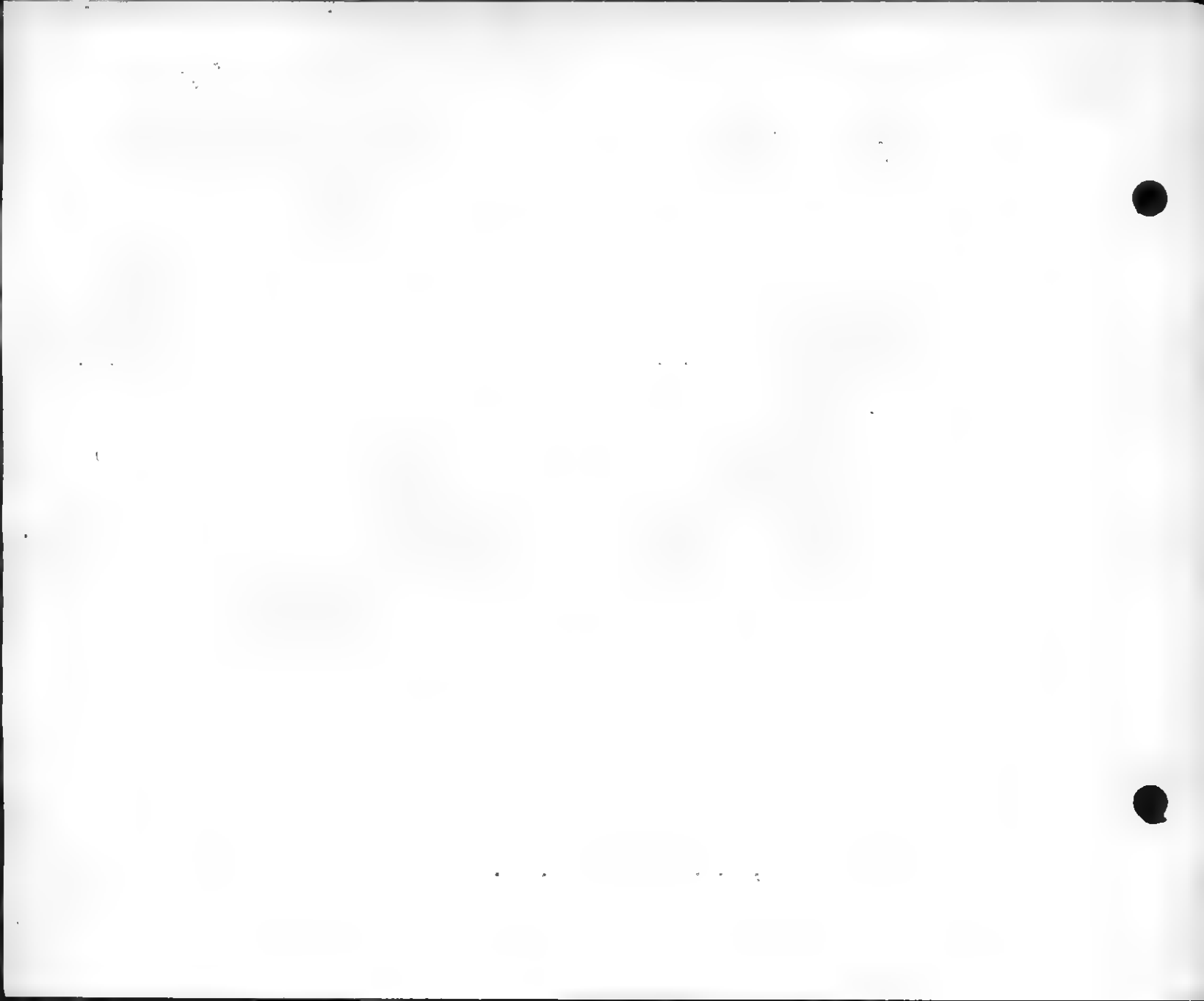
07126

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Prince George's b MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if not usual residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Riverdale		c LENGTH OF STAY IN b DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial Hospital		d STREET ADDRESS 3739 Marlborough Way	
3 NAME OF DECEASED (Type or print) First William Middle C Last Miller		4 DATE OF DEATH Month 5 Day 1 Year 19 67	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5-26-1905
9 AGE (In years last birthday) 61		10 UNDER 1 YEAR Months 5 Days 1 Hours 19 Min 67	
10a USUA. OCCUPATION (Give kind of work done) Mining Engineer		10b KIND OF BUSINESS OR INDUSTRY U.S. Government	
11 BIRTHPLACE (State or foreign country) Pennsylvania		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME John R. Miller		14 MOTHER'S MAIDEN NAME Stella E. Mates	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO. 166 10 3516	
17 INFORMANT Elizabeth Miller Same as #2 (wife)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH minutes over 6 yrs.			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of Item 8)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 5-1-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street city town or county) Bedford Va.	
23a BURIAL: CREMATION REMOVAL (Specify) Burial	23b DATE THEREOF 5/3/67	23c NAME OF CEMETERY OR CREMATORY Oakwood	23d LOCATION City town (County) (State) Bedford Va.
24 FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a REC'D BY REGISTRAR'S SIGNATURE Charles Judge	
DATE MAY 5 1967			



Deputy Medical Examiner for Prince Georges County, released remains to this hospital for disposition and preparation of Death Certificate. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please refile carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07147

CERTIFICATE OF DEATH

08615

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUITLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		d. STREET ADDRESS 5541 68th Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last ELWOOD WITTNER MILSON		4. DATE OF DEATH Month Day Year MAY 31 1967	
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 May 1930
9. AGE (In years lost birthday) 37 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USN		10b. KIND OF BUSINESS OR INDUSTRY USN	
11. BIRTHPLACE (County & State, or foreign country) GIARD, IOWA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SAMUEL MILSON		14. MOTHER'S MAIDEN NAME LUCILLE WITTER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES Jun47-May67		16. SOCIAL SECURITY NO. 484-24-8575	
17. INFORMANT Wife		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO (b) CARDIAC ARREST DUE TO (c) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 31 May, 1967 , to 31 May, 1967 that (X) (we) last saw the deceased alive on 31 May 1967 , and that death occurred at 5:45 AM , from causes and on the date stated above.			
22a. SIGNATURE David L. Piepgras, M.D. M.D.		22b. DATE SIGNED 31 May 1967	
22c. PHYSICIAN'S NAME (Type) DAVID G. PIEPGRAS, CAPT, USAF MC		22d. ADDRESS USAF Hospital Andrews Andrews AFB Wash DC 20331	
23a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		23b. DATE THEREOF 6/5/67	
23c. NAME OF CEMETERY OR CREMATORY W.W. CHAMBERS CO. INC WASH. D.C.		23d. LOCATION (City or town) (County) (State) MIDWAY CITY, CALIF.	
24. FUNERAL DIRECTOR W.W. CHAMBERS CO. INC WASH. D.C.		25. REC'D BY REGISTRAR DATE JUN 7 1967	
26. REGISTRAR'S SIGNATURE Charles Judge		27. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

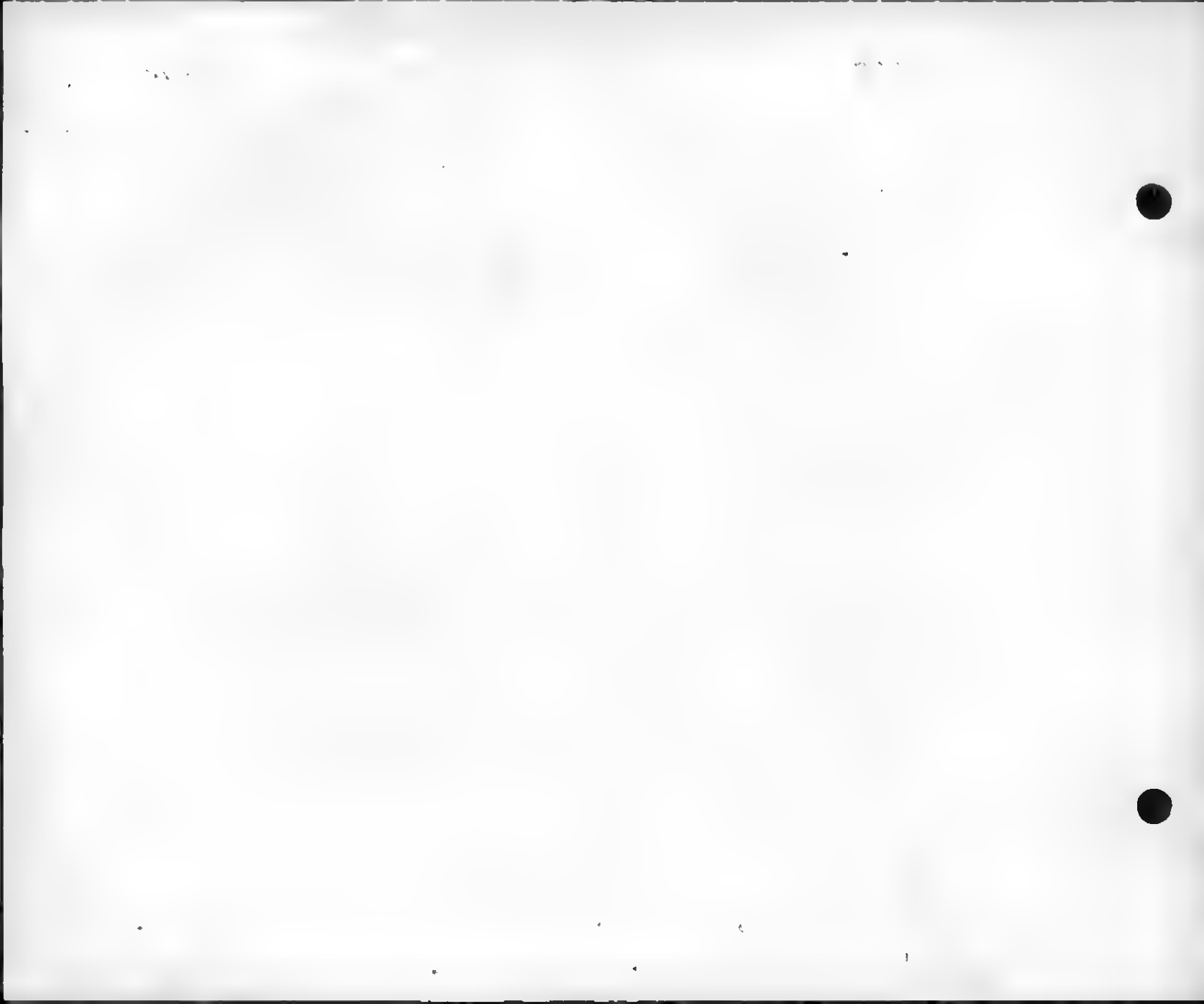
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #12 Film #G389 6/12/67 pc

07148

CERTIFICATE OF DEATH

07127

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Adelphi</i>				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Prince George</i>			
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Paint Branch Nursing Home</i>				d. STREET ADDRESS <i>4000 Oliver St.</i>			
3. NAME OF DECEASED (Type or print) First <i>FRANK</i> Middle <i>MONTEBELLO</i> Last <i>MONTEBELLO</i>				4. DATE OF DEATH Month <i>May</i> Day <i>31</i> Year <i>1967</i>			
5. SEX <i>m.</i>	6. COLOR OR RACE <i>w.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-28-1880</i>	9. AGE (In years last birthday) <i>87 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>		10. IF UNDER 24 HRS Hours <i>0</i> Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gardener</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Gardener</i>		11. BIRTHPLACE (County & State or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? <i>Italy</i>	
13. FATHER'S NAME <i>Francis Montebello</i>				14. MOTHER'S MAIDEN NAME <i>Helen Grayman</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO <i>579148018</i>		17. INFORMANT <i>Rose LaVining</i> Address <i>Hyattsville</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral vascular accident</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i> <i>10 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <i>19</i> a.m. <i>0</i> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <i>11</i> (this hospital) attended the deceased from <i>12-7</i> , 19 <i>66</i> to <i>5-31</i> , 19 <i>67</i> , that <i>11</i> (we) last saw the deceased alive on <i>5-31</i> , 19 <i>67</i> , and that death occurred at <i>11:00</i> P.M. from causes and on the date stated above.							
22a. SIGNATURE <i>R.D. Bauer M.D.</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>R.D. Bauer M.D.</i>				22d. ADDRESS <i>2515 Buck Lodge Rd. Oak Park - Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>June 5, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>MT. OLIVET</i>		23d. LOCATION (City or Town) (County) (State) <i>WASHINGTON, D.C.</i>	
24. FUNERAL DIRECTOR <i>GASCH'S</i> <i>4739 Baltimore Ave. Hyattsville, Md.</i>				25a. REC'D BY REGISTRAR <i>JUN 5 1967</i>		25b. REGISTRAR'S SIGNATURE <i>John P. Judge</i>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

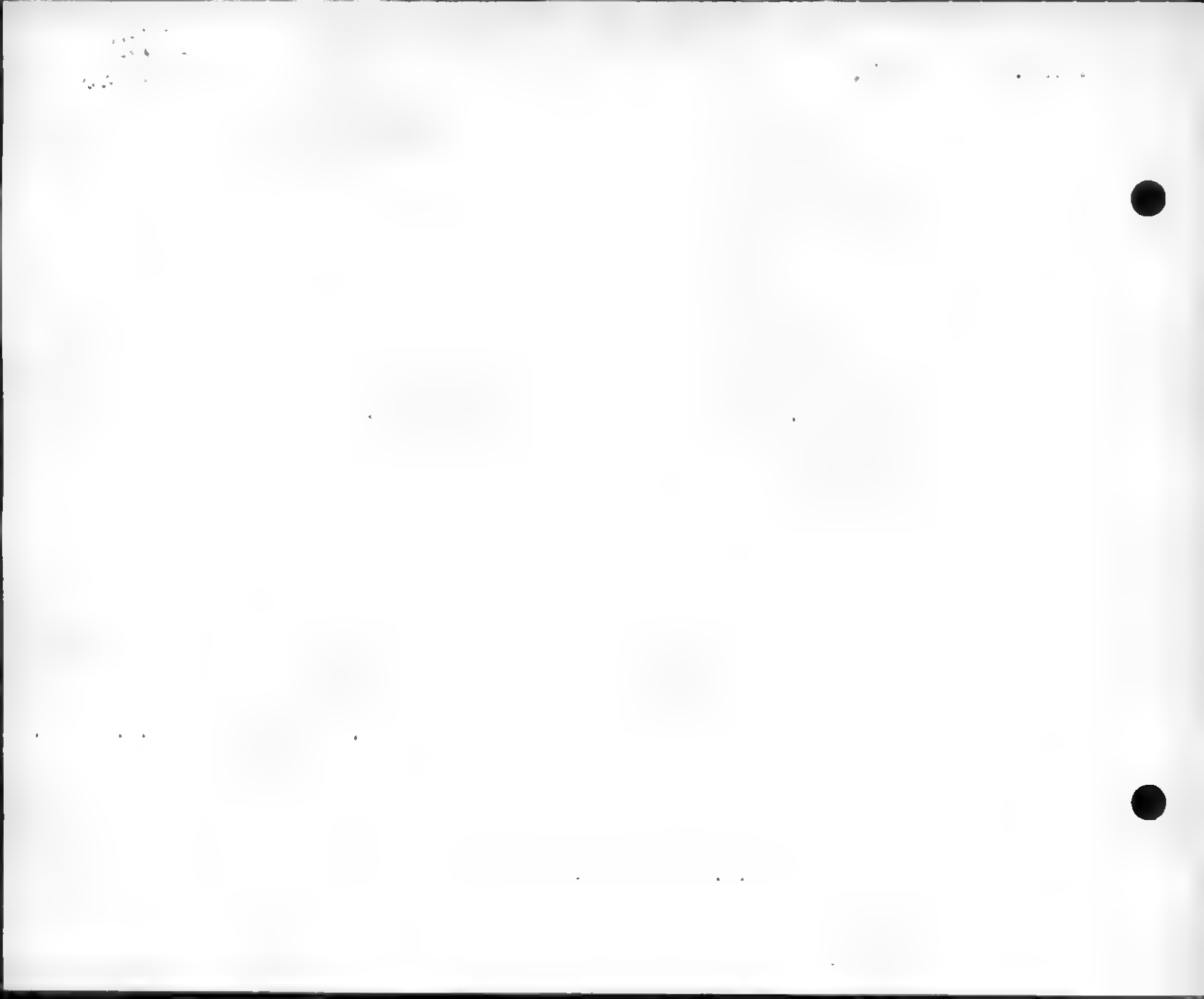
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07143

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07128

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN IB DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's General Hospital				d. STREET ADDRESS 4105 Southern Avenue			
3 NAME OF DECEASED (Type or print) First Middle Last William Thomas Moore				4 DATE OF DEATH Month Day Year 5 5 19 67			
5 SEX Male		6 COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 4-16-25	
9 AGE (in years last birthday) 42 yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant				10b. KIND OF BUSINESS OR INDUSTRY Self-Employed		11 BIRTHPLACE (State or foreign country) Washington DC	
12 CITIZEN OF WHAT COUNTRY?							
13 FATHER'S NAME Robert M. Moore, Sr				14 MOTHER'S M maiden NAME Boulah M. Moore			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II & Korea				16 SOCIAL SECURITY NO 579 22 5731		17 INFORMANT Beverly H. Moore 5012 Canterbury Way SE Temple Hills, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laceration of brain DUE TO (b) Skull fracture DUE TO (c) driver of car which ran off road and hit tree						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour or min 2:25am 5-5 1967				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, playground, etc.) 4300 Suitland Rd. Suitland P.G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D., Riverdale, Maryland				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
23a. BURIAL CREMATION REMOVAL Specified Burial				23b. DATE THEREOF May 8-1967			
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION (City or town, county, State) Suitland, Maryland			
25a. REC'D BY REGISTRAR MAY 9 1967				25b. REGISTRAR'S SIGNATURE Charles Judge			



07150

CERTIFICATE OF DEATH

07129

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-attach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Bladensburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 4901 Taylor Street	
3. NAME OF DECEASED (Type or print) Julia First L. Middle Morrison Last		4. DATE OF DEATH Month May Day 31 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 18, 1881
9. AGE (in years) 85		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Henry R. Kirk		14. MOTHER'S MAIDEN NAME Julia Cox	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Loretta C. Flood Same as #2 (daughter)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Cardiac Decompensation</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>lost</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pericarditis Acute</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-1</u> , 19 <u>50</u> , to <u>5-31</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>5-27</u> 19 <u>67</u> and that death occurred at <u>2:15</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>A. Deitz</u>		22b. DATE SIGNED <u>5-31-67</u>	
22c. PHYSICIAN'S NAME (Type) Aaron Deitz, M. D.		22d. ADDRESS Prince George Plaza Hyattsville, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/3/67	
23c. NAME OF CEMETERY OR CREMATORY Glenwood		23d. LOCATION (City or Town) (County) (State) Washington D. C.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JUN 5 1967	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



07151

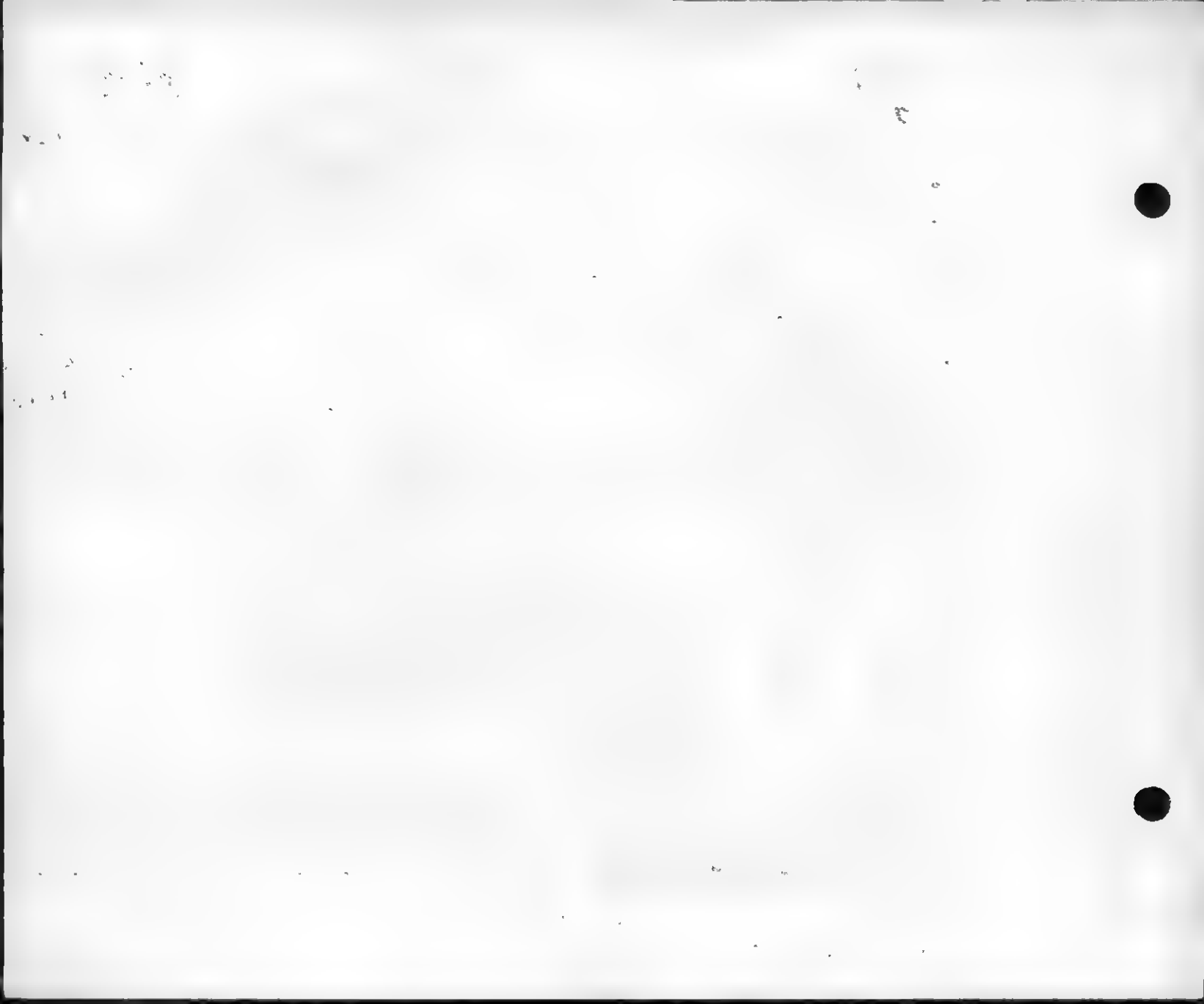
07130

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville		c. LENGTH OF STAY IN 1b 12 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 713 Rittenhouse Street				d. STREET ADDRESS 713 Rittenhouse Street			
3. NAME OF DECEASED (Type or print) Margaret		First S.		Middle Mullen		Last	
4. DATE OF DEATH May 30		Month		Day		Year 19 67	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 17, 1908		9. AGE (In years last birthday) 58 yrs	10. F UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Dept Manager		10b. KIND OF BUSINESS OR INDUSTRY Woodward & Lothrop		11. BIRTHPLACE (County & State, or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Scotson				14. MOTHER'S MAIDEN NAME Mary Naughton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 577-01-5344		17. INFORMANT Charles Mullen Address 713 Rittenhouse Street W. Hyattsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of Rectum DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/25, 1965 to 5/30, 1967 , that (I) (we) last saw the deceased alive on 5/27, 1967 , and that death occurred at 4:00 P.M. from causes and on the date stated above							
22a. SIGNATURE John F. Finnegan				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 5/31/67	
22c. PHYSICIAN'S NAME (Type) John F. Finnegan				22d. ADDRESS 1746 K. St., N.W., Washington, D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 2, 1967		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D.C.	
24. FUNERAL DIRECTOR Clark E. Wisor Warner E. Pumphrey, Inc.		ADDRESS 8434 Georgia Avenue Silver Spring, Maryland		25a. REC'D BY REGISTRAR JUN 6 1967		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

Page 4 may be retained by the hospital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

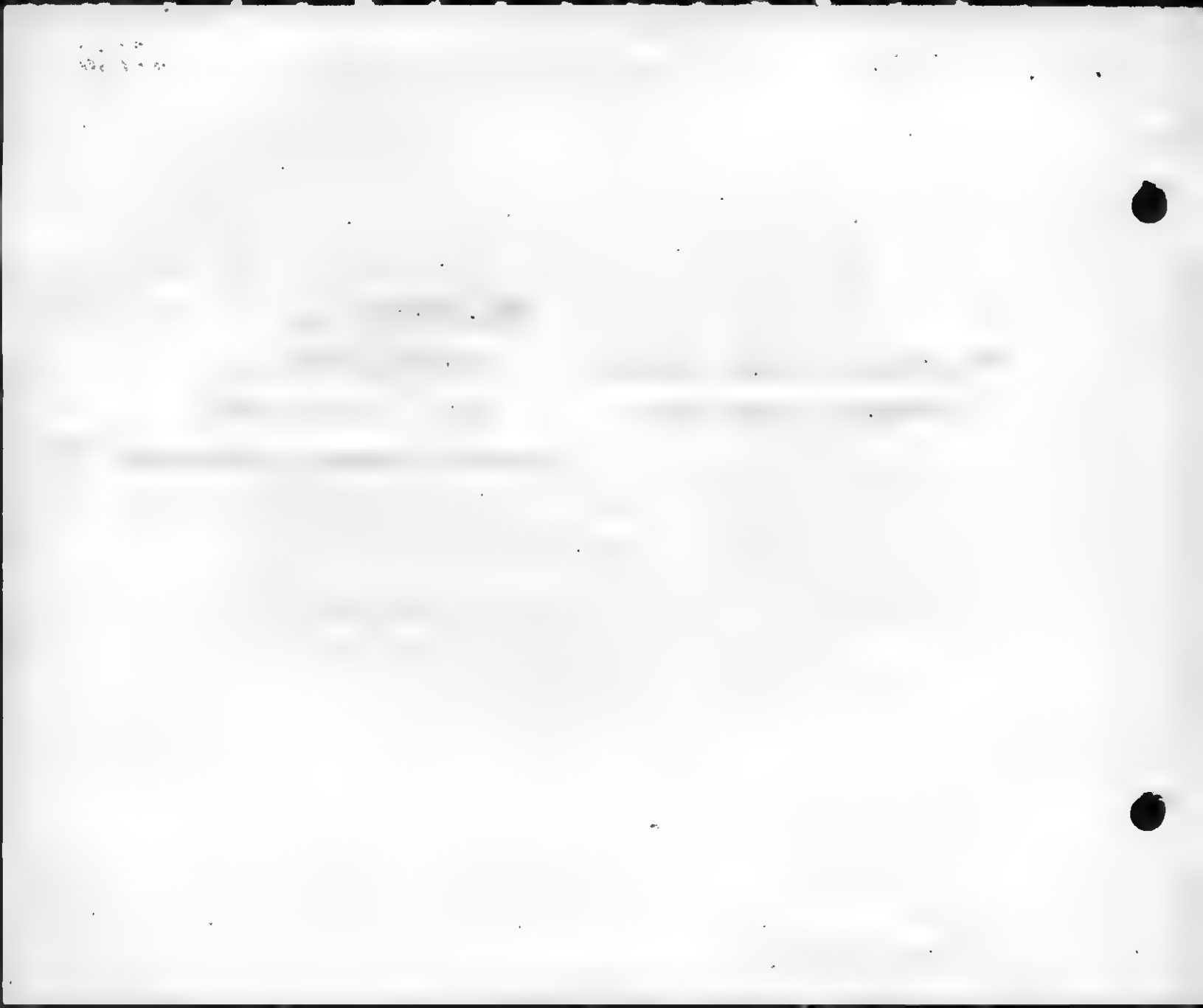
07152

07131

1. PLACE OF DEATH a. COUNTY <i>Pr Geo</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Pr Geo</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry</i>		c. LENGTH OF STAY IN ID <i>DoA</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince Geo General</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>JAMES RAY MUNDALL</i>		4. DATE OF DEATH <i>May 21 19 67</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JAN 24-1922</i>
9. AGE (In years last birthday) <i>45</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Real Estate - Mundell Realty Co.</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>George H. Mundell</i>		14. MOTHER'S MAIDEN NAME <i>Isis M. Ringkey</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>STELLA V. Mundell - SAME AS ITEM #2</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral accident</i> <i>443X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hyper-tensive CV disease</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Year</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Dayton O Watkins</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>DAYTON O WATKINS</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 23-1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Brick Church Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Huttonsville, West Virginia</i>	
24. FUNERAL DIRECTOR <i>Silmons Bros.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE		DATE <i>MAY 22 1967</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate must be completed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07153

CERTIFICATE OF DEATH

07132

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>PR. GEORGES.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Washington D.C.</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) <u>CLINTON</u>		c. LENGTH OF STAY in 1b <u>19 days</u>	
d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) <u>Blue View Gardens</u>		d. STREET ADDRESS <u>1824 17th St. N.W.</u>	
3 NAME OF DECEASED (Type or print) First <u>AGATHA B.</u> Middle <u>MUSE</u> Last <u>MUSE</u>		4 DATE OF DEATH Month <u>5-</u> Day <u>18</u> Year <u>1967</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3-21-1891</u>
9 AGE (in years lost birthday) <u>76</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>President Apts. Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>APT BLDG.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>John Benedikt</u>		14 MOTHER'S MAIDEN NAME <u>Catherine Schuetter</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>577-03-4150-A</u>	
17 INFORMANT <u>Miss ELEANOR CHARRIS-1824-179 St.</u>		Address <u>WASH. D.C.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VASCULAR COLLAPSE</u> <u>1621</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMATOSIS</u> DUE TO (c) <u>BRONCHOGENIC CARCINOMA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 WEEKS</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21 I certify that (I) (this hospital) attended the deceased from <u>4-29</u> , 19 <u>67</u> , to <u>5-18</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>5-17</u> , 19 <u>67</u> , and that death occurred at <u>1:50 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Alfred R. Lapin, M.D.</u>		22b. DATE SIGNED <u>5/18/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN, M.D.</u>		22d. ADDRESS <u>CLINTON, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5/23/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Geo. Wash. Memo. Park</u>	23d. LOCATION (City or Town) (County) (State) <u>River Rd. Extra-Hamshire, MD</u>
24. FUNERAL DIRECTOR <u>W. W. Chambers Co.</u>		25a. REC'D BY REGISTRAR <u>WASH. D.C.</u>	
25b. REGISTRAR'S SIGNATURE <u> </u>		DATE <u>MAY 29 1967</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07154

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07133

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				e. STREET ADDRESS 6110 Breezwood Court, Apt. 301			
3. NAME OF DECEASED (Type or print) First John Middle Charles Last Negron				4. DATE OF DEATH Month 5 Day 31 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 Nov. 1938	9. AGE (in years last birthday) 28 yrs	10. FUNERAL 1 YEAR Months 1 Days 1 Hours 1 Min 1		11. IF UNDER 24 HRS Hours 1 Min 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney			10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (State or foreign country) New York City, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Eustaquio Negron				14. MOTHER'S MAIDEN NAME Helena Correa			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv. etc.) Yes 7-3-60 6-4-66				16. SOCIAL SECURITY NO 066-34-4920		17. INFORMANT Mrs. Frieda Negron (above address) (wife)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Occlusion of anterior descending coronary artery DUE TO Arteriosclerotic heart disease, severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH minutes unknown	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural Causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D.				22. DATE SIGNED 6-1-67			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				Address (Street, city, town or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 6/3/67		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION City Colmar Manor, Md. (County) (State)	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.				25. REC'D BY REG. TRAK JUN 5 1967 R.C. TRAK SIGNATURE Charles Judge			



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 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 Item #8 Film #1339 6/6/67 pc

07155
 CERTIFICATE OF DEATH

07134

1 PLACE OF DEATH a COUNTY <u>Prince Georges</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. GEO.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>		c LENGTH OF STAY IN 1b <u>6 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Southern Maryland Gen. Hosp.</u>		d STREET ADDRESS <u>7033 ALLENTOWN RD.</u>	
3 NAME OF DECEASED (Type or print) First <u>Eugene</u> Middle <u>Newman</u> Last <u>Newman</u>		4 DATE OF DEATH Month <u>May</u> Day <u>28</u> Year <u>19 67</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11/1/89</u>
9 AGE (In years, last birthday) <u>75</u> yrs		10 IF UNDER 1 YEAR Months <u>1</u> Days <u>15</u> Hours <u>15</u> Min <u>15</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>Pr. Geo's. Co. Md.</u>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <u>Eugene Newman</u>		14 MOTHER'S MAIDEN NAME <u>Mary E. Proctor</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16 SOCIAL SECURITY NO	
17 INFORMANT <u>Mary E. Neal</u>		Address <u>7033 Allemtown Rd. Clinton, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE FAILURE</u>			
DUE TO (b) <u>CHRONIC PULMONARY DISEASE</u>			
DUE TO (c) <u>WITH EMPHYSEMA AND CONGESTIVE HEART FAILURE</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTED TO CAUSE OF DEATH (IF EITHER, NOTIFY ATTORNEY EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c TIME OF INJURY Month, Day, Year <u>None</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office, playground, etc.) <u>None</u>		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>OCT 19 57</u> to <u>PRESENT</u> that (I) (we) last saw the deceased alive on <u>MAY 27 19 67</u> , and that death occurred at <u>9:45 AM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Arthur Shaver Jr.</u> M.D.		22b. DATE SIGNED <u>5/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR.</u>		22d ADDRESS <u>8808 OLD BRANCH AVE. CLINTON, MD.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Burial</u>	<u>May 31/67</u>	<u>St. John's Ch. Cemetery</u>	<u>Clinton Pr. Geo. Md.</u>
24 FUNERAL DIRECTOR <u>Mustel Adams Ciguasco, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 8 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0247

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coffin papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07156

CERTIFICATE OF DEATH

07135

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New Hampshire b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Keene	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greenbelt Nursing Home		d. STREET ADDRESS 53 Trobate Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edward Middle Peter Last Nolin		4. DATE OF DEATH Month May Day 1 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1888
9. AGE (In years last birthday) yrs 79		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Men's clothing		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (County & State, or foreign country) New Hampshire		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Pierre Nolin		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) (If yes give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO 002 01 0284	
17. INFORMANT Barbara McLeod		5213 Marnum St. Bladensburg, Md.	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH 1 Day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Concussion of Frontal		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 1, 1966 , to 5-1-67 , that (I) (we) last saw the deceased alive on 5-1-67 , and that death occurred at 3P M, from causes and on the date stated above			
22a. SIGNATURE Donald C. Edgken		22b. DATE SIGNED 5-1-67	
22c. PHYSICIAN'S NAME (Type) DONALD C. EDGKEN		22d. ADDRESS Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-5-67	
23c. NAME OF CEMETERY OR CREMATORY ST. JOSEPH		23d. LOCATION (City or Town) (County) (State) KEENE, NEW HAMPSHIRE	
24. FUNERAL DIRECTOR FRANCIS GASCH'S SONS		25a. REC'D BY REG STRAR MAY 5 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

10-10-10



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07157

CERTIFICATE OF DEATH

07136

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton, Md.</u>		c. LENGTH OF STAY IN <u>6 1/2 hrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton, Md.</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Southern Maryland General Hospital</u>	
d. STREET ADDRESS <u>4020 Brooks Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARIANNE</u> Middle <u>C</u> Last <u>NEWMAN</u>		4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-20-02</u>
9. AGE (In years last birthday) <u>64</u> yrs		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>18</u> Hours <u>18</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Zanger, Ferdinand</u>		14. MOTHER'S MAIDEN NAME <u>Krause, Sophia</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>385-010703</u>	
17. INFORMANT <u>Mr. Ward, Barnett, Clinton, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> DUE TO (b) <u>Myocardial Infarction and</u> DUE TO (c) <u>Massive G.I. Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3-6</u> <u>hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus - possible Ulcers</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-8</u> , 19 <u>67</u> , to <u>5-8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-8</u> , 19 <u>67</u> , and that death occurred at <u>9:15</u> p.m., from causes and on the date stated above.			
22a. SIGNATURE <u>Alfred R. Lapin</u> M.D.		22b. DATE SIGNED <u>MAY 9th, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R LAPIN, MD</u>		22d. ADDRESS <u>CLINTON, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY 12, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BATTLE CREEK MEMORIAL PARK</u>		23d. LOCATION (City or town) (County) (State) <u>BATTLE CREEK, MICH.</u>	
24. FUNERAL DIRECTOR <u>M. W. HYSONG CO INC.</u> ADDRESS <u>Per Thomas M. Hysong</u>		25a. REC'D BY REGISTRAR <u>WASH. D.C.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE <u>MAY 10 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11/10/10

25

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

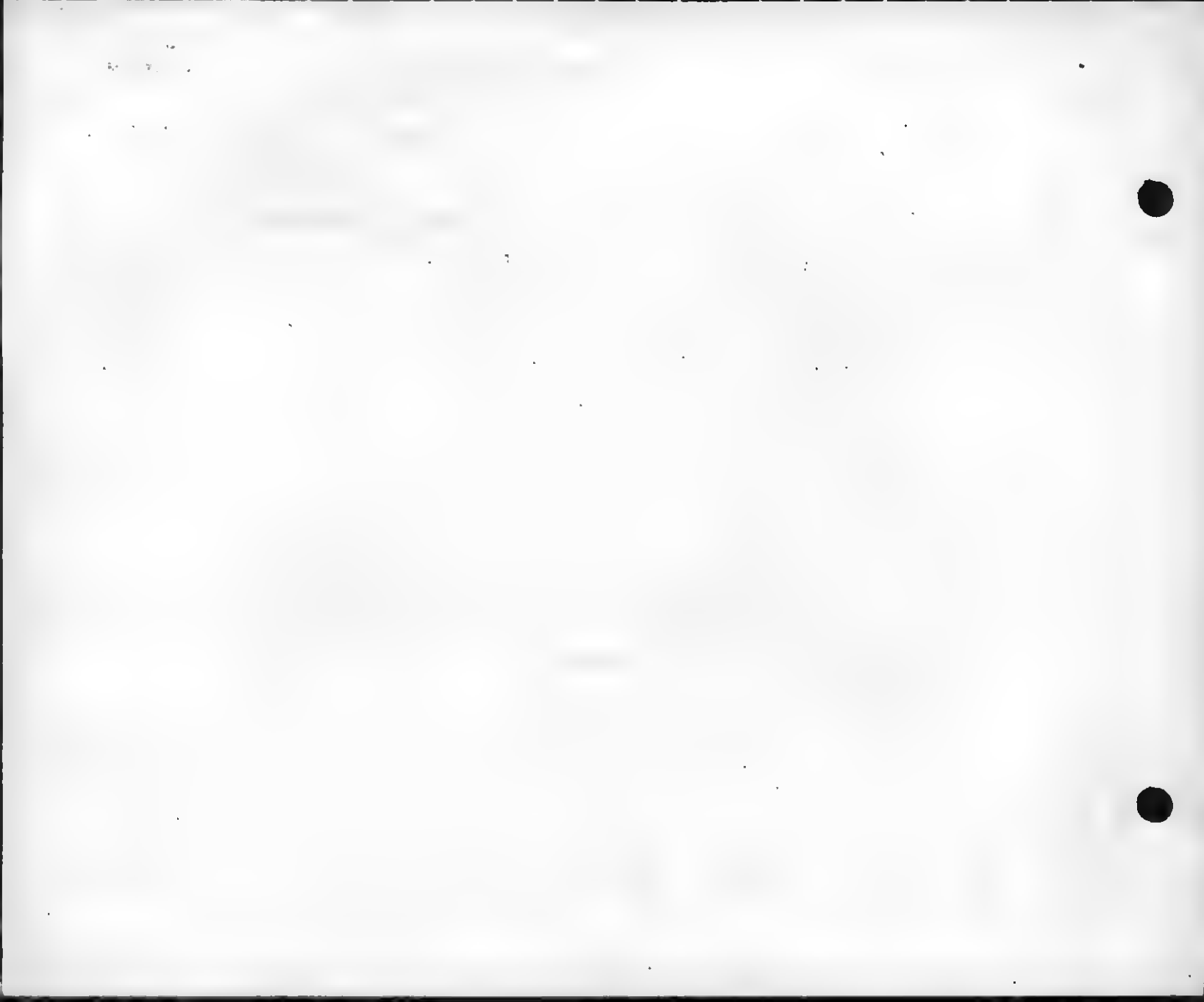
07158

CERTIFICATE OF DEATH

07137

1 PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PRINCE CHARLES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>			c. LENGTH OF STAY in 1b <u>2-21-67</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WALDORF</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PINEVIEW GARDENS</u>				d. STREET ADDRESS <u>RT. 1 BOX 404</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>ANN T. NORVILL</u>				4. DATE OF DEATH Month Day Year <u>5 7 1967</u>			
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-15-1895</u>	9 AGE (in years last b. day) <u>71</u> yrs	10 IF UNDER 1 YEAR Months Days Hours Min		11 IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>		11 BIRTHPLACE (County & State, or foreign country) <u>CULPEPPER, VA.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HOWARD H. HANSBOROUGH</u>				14. MOTHER'S MAIDEN NAME <u>HARRIET BONTZ</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO. <u>218 347 022-B</u>		17 INFORMANT <u>HUSBAND</u>		Address <u>SAME</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO (b) <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>unknown</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 1, 1967</u> to <u>May 7, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 17, 1967</u> , and that death occurred at <u>3:30 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>H. G. Hadley</u>				22b. DATE SIGNED <u>May 7 67</u>		22c. PHYSICIAN'S NAME (Type) <u>H. G. HADLEY</u>	
22d. ADDRESS <u>4601 Nichols Ave S.W.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-12-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Waldorf, Charles Co., Md.</u>	
24. FUNERAL DIRECTOR <u>Hunt Funeral Home Waldorf Md</u>				25a. REC'D BY REGISTRAR <u>MAY 11 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



7

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07153

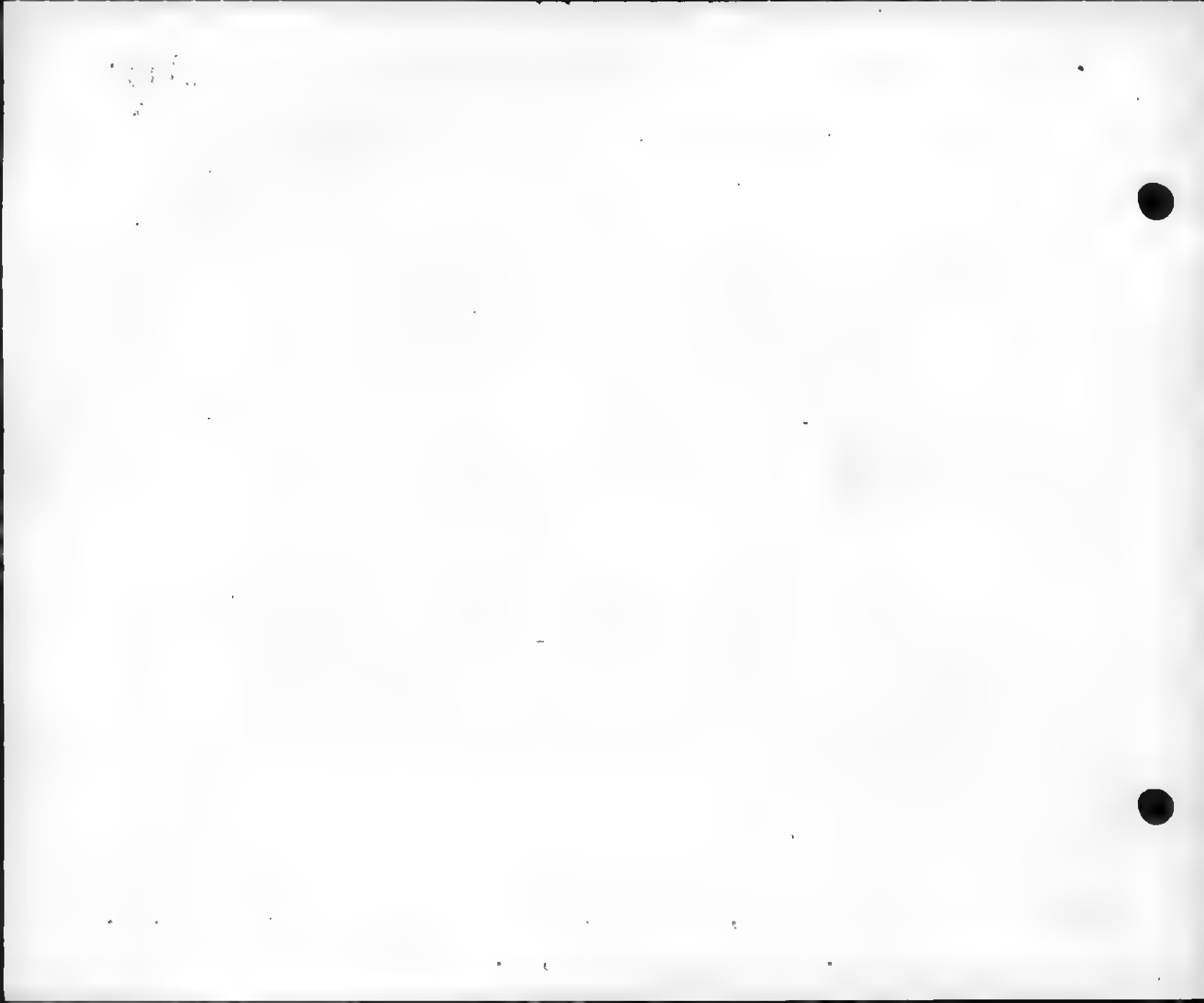
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07138

1 PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE COUNTY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>NEWHEMSHIRE AVE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL ADELPHI, MD</u>		c. LENGTH OF STAY IN lb <u>3 mos</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PAINT BRANCH NURSING HOME</u>		d. STREET ADDRESS <u>16700 NEWHEMSHIRE AVE</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>BRADLEY</u> <u>-</u> <u>NORWOOD</u>		4 DATE OF DEATH Month Day Year <u>May</u> <u>20</u> <u>1967</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7/29/1897</u>
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GOVERNMENT</u>		10b KIND OF BUSINESS OR INDUSTRY <u>-</u>	9 AGE (In years last birthday) <u>69</u> yrs
11 BIRTHPLACE (County & State or foreign country) <u>BOYD MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>BRADLEY E. NORWOOD</u>		14 MOTHER'S MAIDEN NAME <u>MARGARITA TRAIL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes give war or dates of service) <u>(Yes)</u>		16 SOCIAL SECURITY NO. <u>213-16-2654</u>	
17. INFORMANT <u>MARTHA, NORWOOD</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO (b) <u>Pneumonia</u> DUE TO (c) <u>Cerebral vascular accident (map)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u> <u>1 wk.</u> <u>1 wk.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral vascular accident years ago</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>3-29</u> , 19 <u>67</u> , to <u>5-20</u> , 19 <u>67</u> , that (1) (we) lost the deceased alive on <u>5-19</u> , 19 <u>67</u> , and that death occurred on <u>02:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>R.D. Bauer MD</u>		22b. DATE SIGNED <u>5-20-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R.D. Bauer, M.D.</u>		22d. ADDRESS <u>2513 Buck Lodge Rd. Adelphi, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>May 23, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Burtonsville</u>	23d. LOCATION (City or Town) (County) (State) <u>Burtonsville, Md.</u>
24 FUNERAL DIRECTOR <u>Francis H. Barber</u>		25a. REC'D BY REGISTRAR <u>MAY 23 1967</u>	
ADDRESS <u>Laytonsville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07160

CERTIFICATE OF DEATH

07139

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 hr 30 m	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Minnie Middle A Last O'Brien		4. DATE OF DEATH Month May Day 23 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 Oct., 1915
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months 5 Days 1 Hours 1 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Wash., D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Theodore Cameron		14. MOTHER'S MAIDEN NAME Susan Greer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mr. Thos. J. O'Brien (above address)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Pulmonary Edema 4601 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Myocardial Infarction DUE TO (c) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 2 hrs 3 hrs 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July , 1950, to 5/23 , 1967, that (I) (we) last saw the deceased alive on 5/23 , 1967, and that death occurred at 2:48 M, from causes and on the date stated above			
22a. SIGNATURE Norman J. Comer		22b. DATE SIGNED 5/23/67	
22c. PHYSICIAN'S NAME (Type) Norman J. Comer		22d. ADDRESS 3503 Penny St Mt Rainier Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/26/67	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a. REC'D BY REGISTRAR MAY 29 1967	
ADDRESS Mt. Rainier, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10/1/44

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07161

CERTIFICATE OF DEATH

07140

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. G.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> <u>16-1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>				d. STREET ADDRESS <u>6712 Darby Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Effie M. Owens</u>				4. DATE OF DEATH Month Day Year <u>May 13 1967</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/28/99</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hosiery worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Golden Belt Mfg.</u>		11. BIRTHPLACE (County & State or foreign country) <u>Wilson Co., N. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Major Barnett</u>			
14. MOTHER'S MAIDEN NAME <u>Minnie Bunn</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>242-01-7086</u>				17. INFORMANT Address <u>Mrs. Minnie Weil, 6712 Darby Rd., Hyattsville Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>157X</u> DUE TO (b) <u>Carcinoma of the pancrea</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>May 4, 1967</u> to <u>May 13, 1967</u> , that (I) (we) lost saw the deceased alive on <u>May 13, 1967</u> , and that death occurred at <u>10:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Hernandez</u>				22b. DATE SIGNED <u>5/14/67</u>		22c. PHYSICIAN'S NAME (Type) <u>T. J. HERNANDEZ, MD</u>	
22d. ADDRESS <u>PRINCE Geo. Gen Hospital.</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
23b. DATE THEREOF <u>5-16-1967</u>				23c. NAME OF CEMETERY OR CREMATORY <u>MAPLEWOOD CEMETERY</u>			
23d. LOCATION (City or Town) (County) (State) <u>DURHAM N.C.</u>				24. FUNERAL DIRECTOR <u>MURPHY FUNERAL HOME</u>			
25a. REC'D BY REGISTRAR <u>Charles Judge</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
25c. DATE <u>MAY 18 1967</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

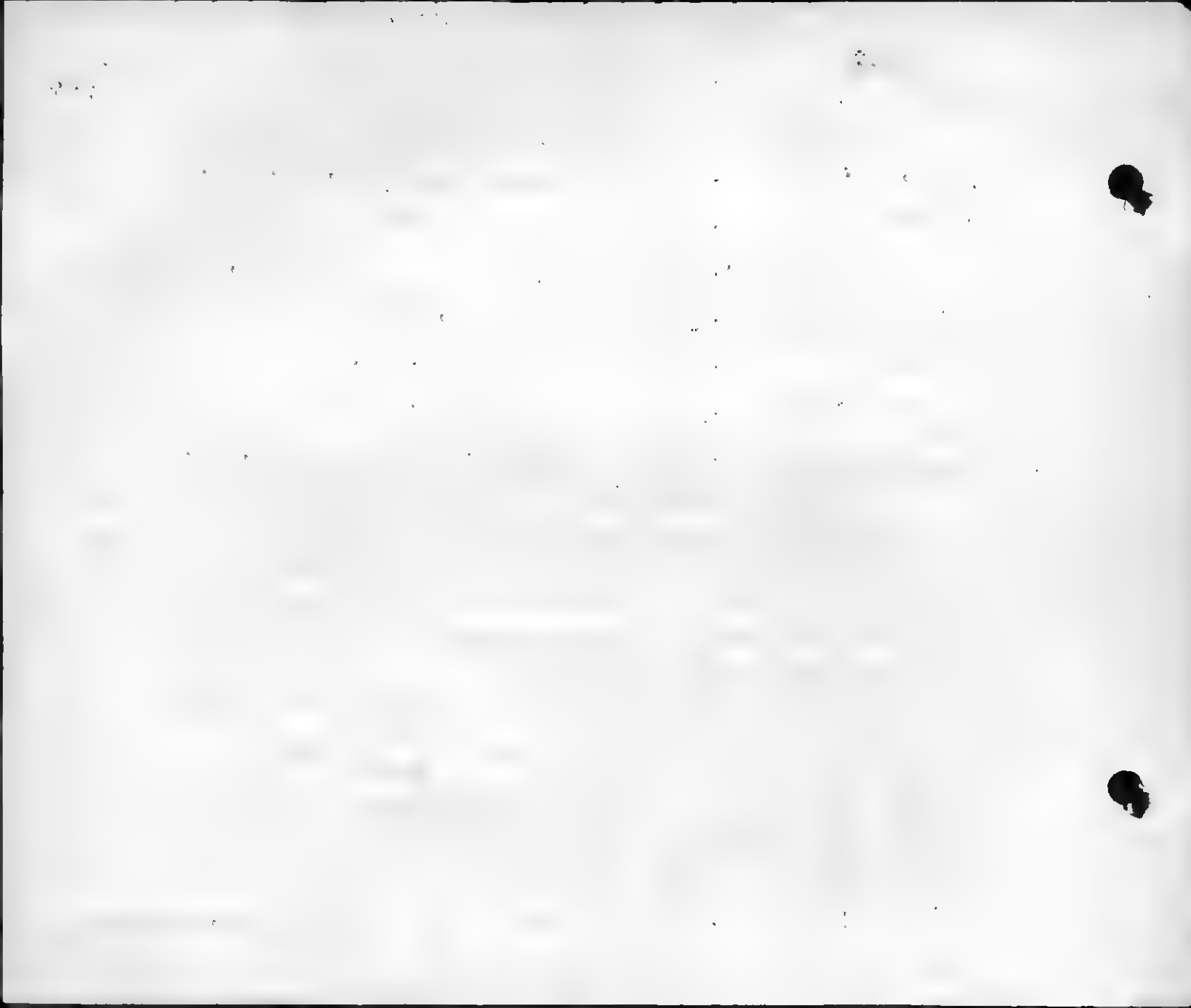
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07162

CERTIFICATE OF DEATH

07141

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock, Md. RFD.	
c. LENGTH OF STAY IN TB 6 weeks		d. STREET ADDRESS none	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) residence		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Verna M. Parks		4. DATE OF DEATH May 5, 1967	
5. SEX male		6. COLOR OR RACE white	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 29, 1903	
9. AGE (In years last birthday) 64 yrs		10. IF UNDER 1 YEAR Months Days 64	
11. IF UNDER 24 HRS. Hours Min. 64		12. CITIZEN OF WHAT COUNTRY? USA.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY none	
13. FATHER'S NAME Robert S. Venable		14. MOTHER'S MAIDEN NAME Lula M. Imbert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Lewis M. Parks		Address Bowie, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia DUE TO (b) carcinoma of liver DUE TO (c) carcinoma of liver		INTERVAL BETWEEN ONSET AND DEATH 2 days 4 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) I diabetes mellitus 2 hypertension			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/15/67 , 19....., to 5/5/67 , 19....., that (I) (we) last saw the deceased alive on 5/4/67 , 19....., and that death occurred at 3:00 PM , from the causes and on the date stated above.			
22a. SIGNATURE Henry A. Wiseman		22b. DATE SIGNED MAY 11 1967	
22c. PHYSICIAN'S NAME (Type) Henry A. Wiseman		22d. ADDRESS Federalsburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 5/8/67	
23c. NAME OF CEMETERY OR CREMATORY Concord Cem.		23d. LOCATION (City, town or county) (State) Federalsburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Harvey Williams		25. REC'D BY REGISTRAR Charles Judge	
25. DATE MAY 11 1967		26. REGISTRAR'S SIGNATURE Charles Judge	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. Fill in pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07163

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07142

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived f institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY N 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George General Hospital		e. STREET ADDRESS Capitol Heights 1528 62nd. Place	
3 NAME OF DECEASED (Type or print) First DUSAN Middle E. Last PARMA		4 DATE OF DEATH Month 5 Day 11 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2 Jan. 1890
9 AGE (n years lost birthday) 77 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAWYER	
10b KIND OF BUSINESS OR INDUSTRY RETIRED		11 BIRTHPLACE (State or foreign country) CZECHOSLOVAKIA	
12 CITIZEN OF WHAT COUNTRY? U S A		13 FATHER'S NAME EDWARD PARMA	
14 MOTHER'S MAIDEN NAME BETTY NEUMAN		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO 360 26 0972		17 INFORMANT JIRI PARMA Address 1528 62nd PLACE S E	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH minutes over 2 yrs.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		19 WAS A T.O.P.S.Y. PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 5-12-67		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town or county)		23a. RECD BY REGISTRAR MAY 17 1967	
23b. REGISTRAR'S SIGNATURE Charles Judge		23c. LOCATION (City or town) (County) (State) WASHINGTON D.C.	
23d. BURIAL, CREMATION OR REMOVAL (Specify) CREMATION		23e. DATE THEREOF MAY 13 1967	
23f. NAME OF CEMETERY OR CREMATORY LEES CREMATORY		23g. ADDRESS 300 4th ST N.E.	
23h. FUNERAL DIRECTOR LEE FUNERAL HOME		23i. ADDRESS 300 4th ST N.E.	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

37164

07143

1 PLACE OF DEATH a. COUNTY <u>Prince George</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville - md.</u> c. LENGTH OF STAY IN <u>1b</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Regent Rehabilitation Center</u>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMP SPRINGS 1-1</u> d. STREET ADDRESS <u>7704 DUBLIN DRIVE</u> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Dewitt C. Patterson</u> First Middle Last 4 DATE OF DEATH <u>MAY 16 1967</u> Month Day Year		5 SEX <u>Male</u> 6 COLOR OR RACE <u>CAU.</u> 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>6-3-1887</u> 9 AGE (In years last birthday) <u>79</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gov't Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country)		12 CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Nimrod Patterson</u>		14. MOTHER'S MAIDEN NAME <u>Lucindy Reed</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO	
17 INFORMANT <u>EARL G PATTERSON SAME AS #2</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Atherosclerotic heart disease</u> DUE TO (c) <u>5 periods of mild A20-emir</u>		INTERVA. BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>2/25</u> , 19 <u>67</u> , to <u>16 May</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>15 May</u> , 19 <u>67</u> , and that death occurred at <u>12:10 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert J. Hargis</u> M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>Robert J. Hargis</u>		22b. DATES GND <u>16 May 67</u> 22d. ADDRESS <u>6412 Canolton Ct</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)	
24. FUNERAL DIRECTOR <u>Robert E. McElinden</u> <u>Fun Home</u> <u>4308 S. ...</u>		25a. MAY 18 1967 25b. REGISTRAR'S SIGNATURE <u>Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove "barbar" papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07165

CERTIFICATE OF DEATH

07144

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY in 1b 14 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General HOsptial				d. STREET ADDRESS 6931 Allison St.			
3. NAME OF DECEASED (Type or print) First Milton Middle T. Last Patterson				4. DATE OF DEATH Month May Day 4 Year 19 67			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/2/01	
9. AGE (In years lost birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEAM FITTER				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) TENN.	
12. C. T. ZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME JAMES PATTERSON				14. MOTHER'S MAIDEN NAME BLANCHE THORNBURG			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO 577-09-9711		17. INFORMANT FLORENCE H. PATTERSON Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Adenocarcinoma DUE TO 1001 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Intestinal Obstruction DUE TO (c) Metastatic to Lung				INTERVAL BETWEEN ONSET AND DEATH 6 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Nov. , 19 66 to May 4 , 19 67 , that (I) (we) last saw the deceased alive on May 4 , 19 67 , and that death occurred at 8:25 AM from causes and on the date stated above							
22a. SIGNATURE 				22b. DATE SIGNED May 5, 1967		22c. PHYSICIAN'S NAME (Type) Ohannes Sahakyan, M.D.	
22d. ADDRESS 5813 Landover Road, Cheverly, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-8-1967		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM		23d. LOCATION (City or Town) (County) (State) BLADENSBURG, MARYLAND	
24. FUNERAL DIRECTOR W. W. CHAMBERS 60 RIVERDALE, MD				25a. REC'D BY REGISTRAR DATE MAY 11 1967		25b. REGISTRAR'S SIGNATURE 	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

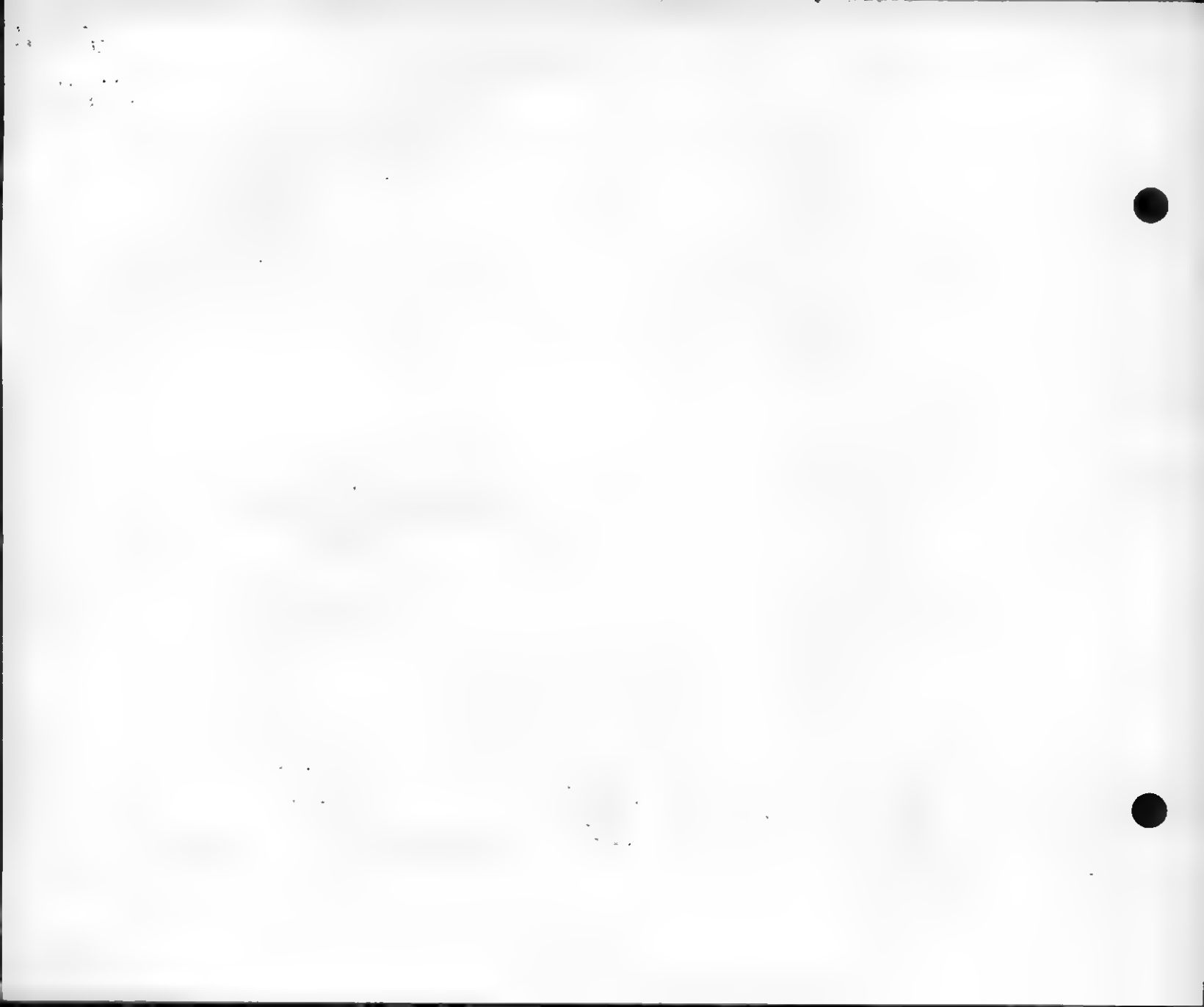
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07166

CERTIFICATE OF DEATH

07145

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George Hospital</u>				d. STREET ADDRESS <u>5802 Greenleaf Rd</u>			
3. NAME OF DECEASED (Type or print) <u>HENRIETTA</u> First Middle Last				4. DATE OF DEATH <u>May 29 1967</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/26/1896</u>	
9. AGE (In years last birthday) <u>71</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Christ</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT <u>William Pearce</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>440x</u> IMMEDIATE CAUSE (a) <u>Arteriosclerotic</u> DUE TO <u>CARDIOVASCULAR</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Disease</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 1961</u> to <u>May 29, 1967</u> that (II) (we) last saw the deceased alive on <u>May 29, 1967</u> , and that death occurred at <u>9:25 PM</u> from causes and on the date stated above.							
22a. SIGNATURE <u>William D. Rossen</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>William D. Rossen</u>				22d. ADDRESS <u>5701 85th AVE, HYATTSVILLE, MD.</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/2/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington</u>		23d. LOCATION (City or Town) (County) (State) <u>Ft Myer, Va.</u>	
24. FUNERAL DIRECTOR <u>Lee Funeral Home</u>				25a. REC'D BY REGISTRAR <u>DUN 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

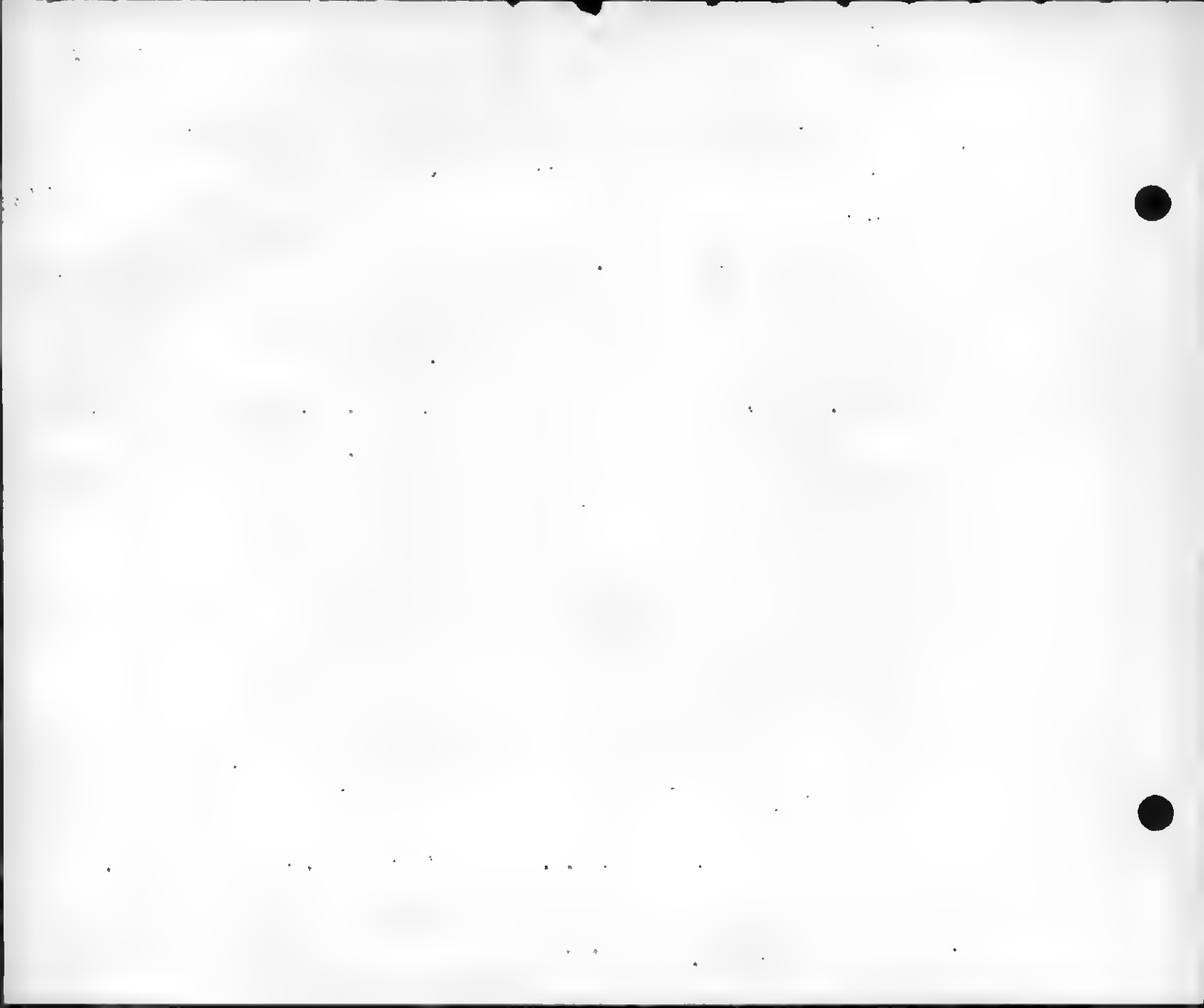


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
07167 Item #8 Film #G386 3/10/67 pc					07146				
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital					d. STREET ADDRESS 7612 Fontainebleau Drive			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Annie J. Penn			4. DATE OF DEATH Month Day Year May 11 1967		5. AGE (In years last birthday) 71 yrs.				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/18/96		9. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James J. Johnson					14. MOTHER'S MAIDEN NAME Daisy M. Wilkerson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 578-20-6797		17. INFORMANT Mrs Clare J. Weger-daughter Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH Today	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from April 24, 1967, to May 11, 1967, that (I) (we) last saw the deceased alive on May 11, 1967, and that death occurred at 10 A.M. from the causes and on the date stated above.									
22a. SIGNATURE <u>Frederick E. Musser, M.D.</u>					22b. DATE SIGNED May 12, 1967				
22c. PHYSICIAN'S NAME (Type) Frederick E. Musser, M.D.					22d. ADDRESS 4410-74th Ave. Hyattsville, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-13-67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Suitland, Md.			
24. FUNERAL DIRECTOR Lee Funeral Home 300-4th St. N.E. Wash., D.C. 20002					25a. REC'D BY REGISTRAR MAY 15 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

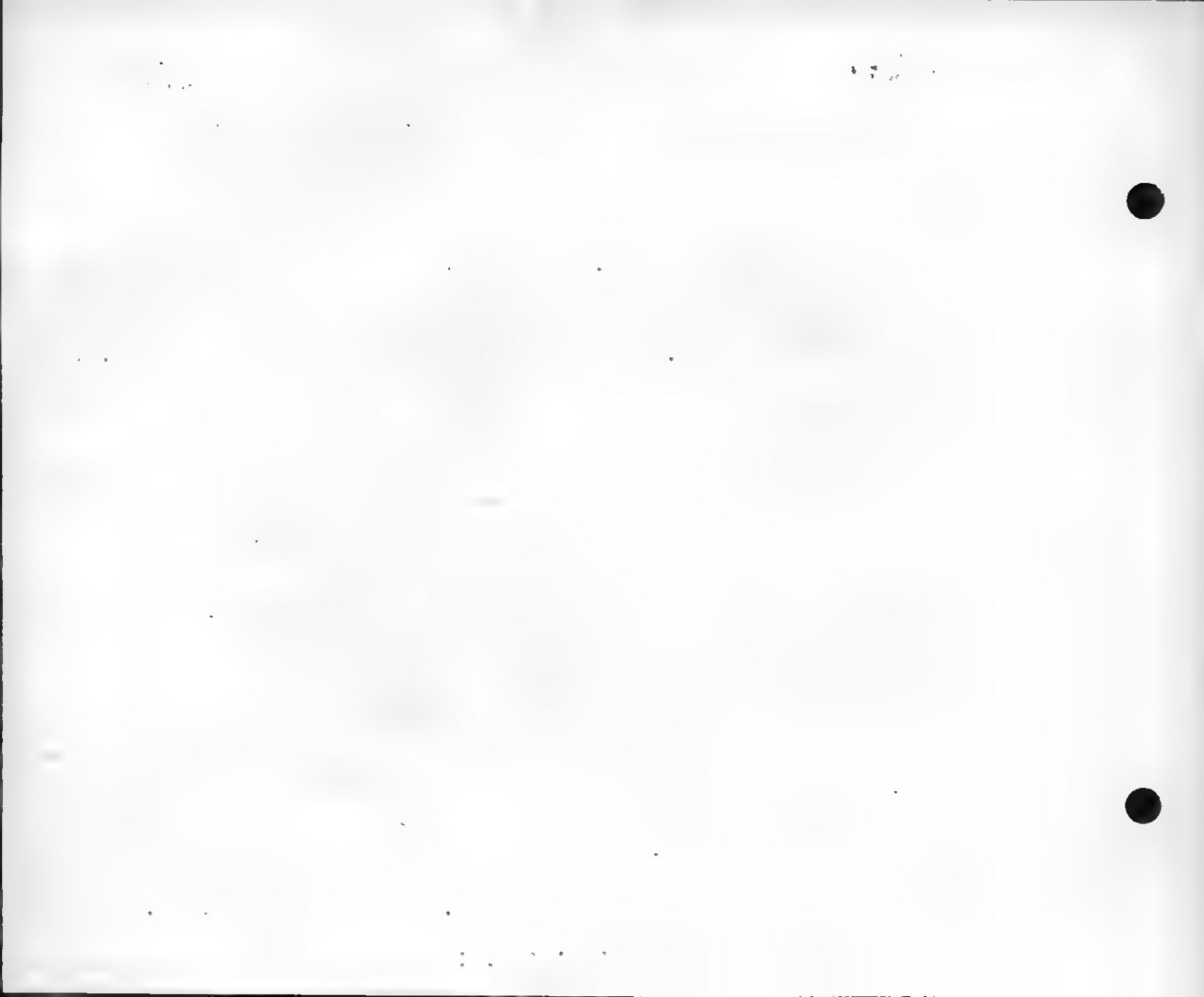


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <div style="text-align: center;">Prince Georges</div> <div style="text-align: right;">MARYLAND</div> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center;">Cheverly</div> c. LENGTH OF STAY IN ID <div style="text-align: center;">2 days</div> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <div style="text-align: center;">Prince Georges General Hospital</div>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <div style="text-align: center;">Maryland</div> b. COUNTY <div style="text-align: center;">Prince Georges</div> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center;">New Carrollton</div> d. STREET ADDRESS <div style="text-align: center;">7612 Fountainbleau Drive</div> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <div style="text-align: center;">Clarence M. Penn</div>		4. DATE OF DEATH Month Day Year <div style="text-align: center;">May 8, 1967</div>						
5. SEX <div style="text-align: center;">Male</div>	6. COLOR OR RACE <div style="text-align: center;">White</div>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <div style="text-align: center;">12/3/94</div>	9. AGE (In years last birthday) <div style="text-align: center;">72 yrs.</div>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="text-align: center;">Inspector</div>	10b. KIND OF BUSINESS OR INDUSTRY <div style="text-align: center;">D.C. Gov't</div>	11. BIRTHPLACE (County & State, or foreign country) <div style="text-align: center;">Virginia</div>	12. CITIZEN OF WHAT COUNTRY? <div style="text-align: center;">U.S.A.</div>
13. FATHER'S NAME <div style="text-align: center;">Jesse Penn</div>			14. MOTHER'S MAIDEN NAME <div style="text-align: center;">Mary Ellen Hardy</div>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <div style="text-align: center;">No No</div>		16. SOCIAL SECURITY NO. <div style="text-align: center;">579 05 9249</div>		17. INFORMANT <div style="text-align: center;">Hospital records</div>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>sublel vascular accident</i> DUE TO (b) <i>thrombosis of rt. vertebral artery? thromboembolism</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <div style="text-align: center;">Pulmonary thrombo-emboli - bilateral</div>						INTERVAL BETWEEN ONSET AND DEATH <div style="text-align: center;">2 day</div>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <div style="text-align: center;">19</div>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>5/6/67</i> , 19 <i>67</i> , to <i>5/8</i> , 19 <i>67</i> , that (I) (<i>we</i>) last saw the deceased alive on <i>5/8/1967</i> , and that death occurred at <i>2:00</i> P.M., from the causes and on the date stated above.								
22a. SIGNATURE <div style="text-align: center;"><i>[Signature]</i></div>				22b. DATE SIGNED <div style="text-align: center;">5/8/67</div>				
22c. PHYSICIAN'S NAME (Type) <div style="text-align: center;">F.E. Musser</div>		22d. ADDRESS <div style="text-align: center;">4410 78th Ave Hyattsville Md</div>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <div style="text-align: center;">Burial</div>	23b. DATE THEREOF <div style="text-align: center;">5/11/67</div>	23c. NAME OF CEMETERY OR CREMATORY <div style="text-align: center;">Cedar Hill Cem.</div>		23d. LOCATION (City, town or county) (State) <div style="text-align: center;">Suitland, Md.</div>				
24. FUNERAL DIRECTOR <div style="text-align: center;">Lee Funeral Home 300-4th St. N.E. Wash. D.C.</div>			25a. REC'D BY REGISTRAR <div style="text-align: center;">MAY 11 1967</div>					
25b. REGISTRAR'S SIGNATURE <div style="text-align: center;"><i>[Signature]</i></div>								



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07163

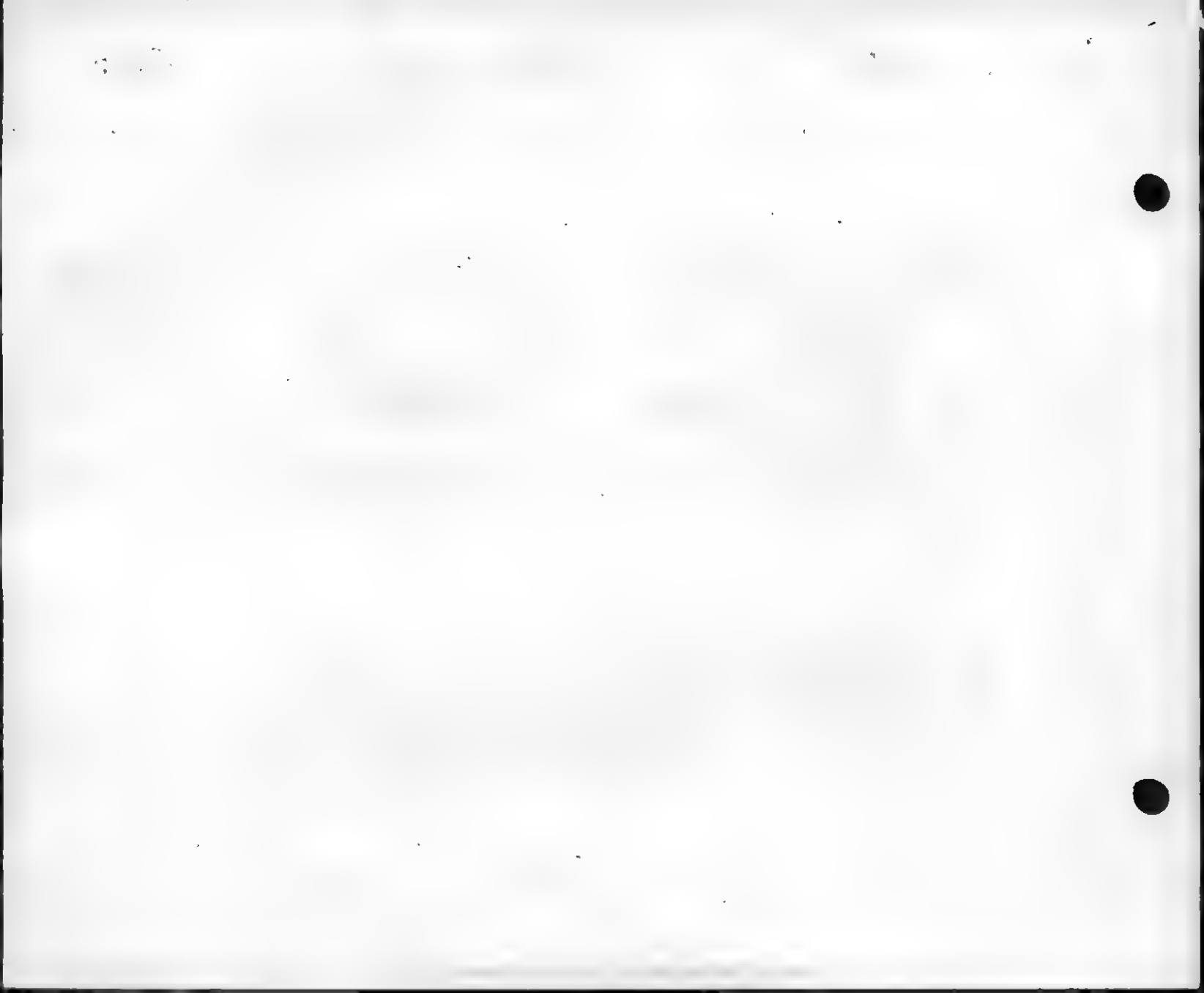
CERTIFICATE OF DEATH

07148

1. PLACE OF DEATH a. COUNTY <u>CLINTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CLINTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>			c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Clinton</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>garden street</u>				d. STREET ADDRESS <u>garden street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JULIA</u> Middle <u>PLACOS</u> Last <u>PLACOS</u>				4. DATE OF DEATH Month <u>11</u> Day <u>11</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-24-1870</u>		9. AGE (In years last birthday) <u>95</u> yrs.	10. IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (County & State or foreign country) <u>MD - CLINTON</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>John Pappas</u>			
14. MOTHER'S MAIDEN NAME <u>Helar</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>110</u>				17. INFORMANT <u>John Pappas</u> Address <u>John Pappas - 264</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>451</u> DUE TO <u>old heart</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>old heart</u> DUE TO <u>old heart</u> (c) <u>old heart</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3</u>
							PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 12-67</u> , 19 <u>67</u> , to <u>May 12-67</u> , 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>May 12-67</u> , 19 <u>67</u> , and that death occurred at <u>11</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Dr. Charles Judge</u>				22b. DATE SIGNED <u>MAY 11 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. Charles Judge</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 12-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery, Arlington, Virginia</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>Simmons Bros & Son</u>				25a. REC'D BY REGISTRAR <u>1461 Good Hope Rd</u>		25b. REGISTRAR'S SIGNATURE <u>Dr. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07170

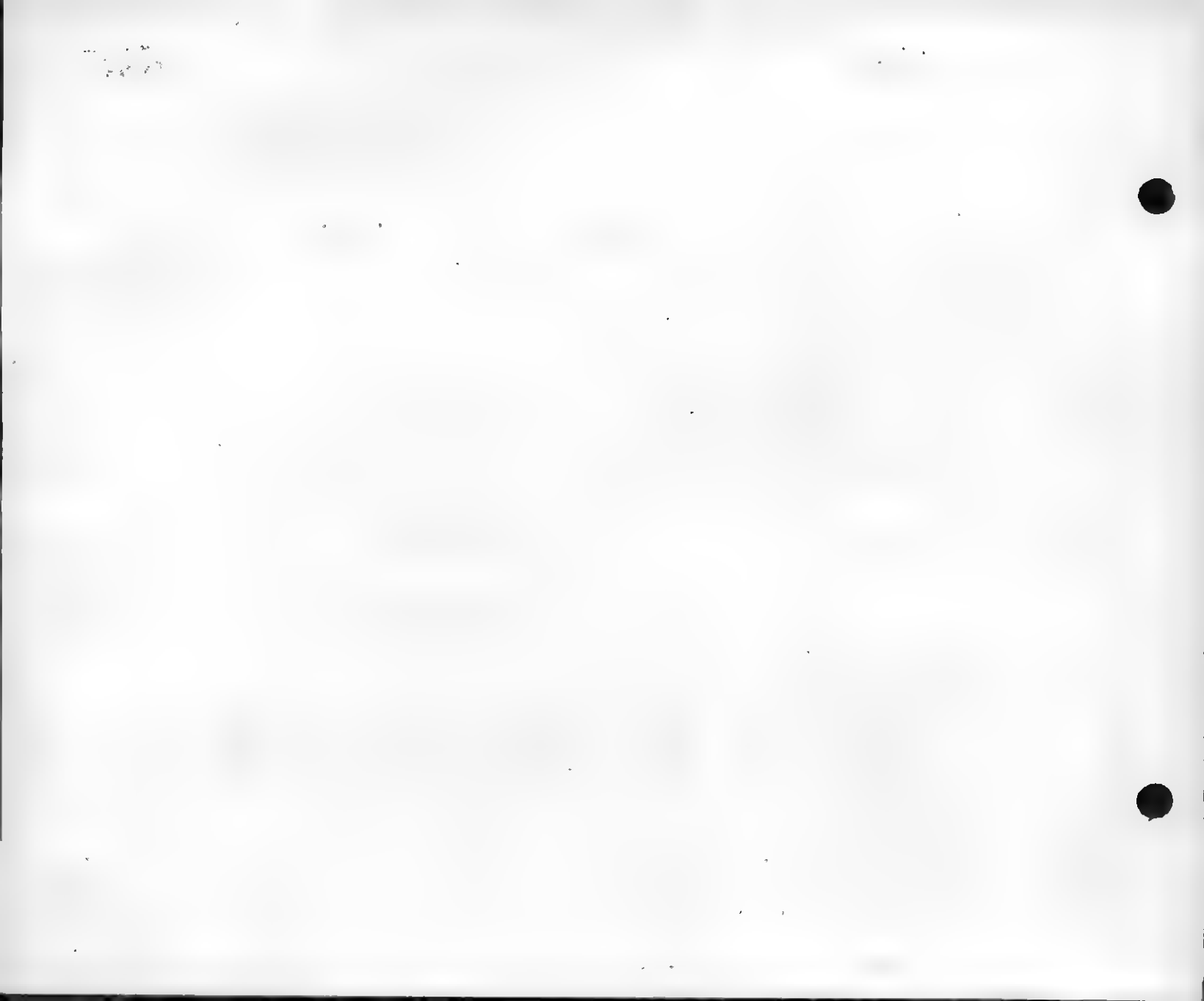
CERTIFICATE OF DEATH

07149

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admision) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland Park, Md.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland Park, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Magnolia Gardens Nursing Home</u>		d. STREET ADDRESS <u>6512 C. St.</u>	
3. NAME OF DECEASED (Type or print) <u>Henry F. POHL</u>		4. DATE OF DEATH <u>5 May 16 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 9, 1876</u>
9. AGE (In years last birthday) <u>90</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 2 YEARS <input type="checkbox"/> 3 YEARS <input type="checkbox"/> 4 YEARS <input type="checkbox"/> 5 YEARS <input type="checkbox"/> 6 YEARS <input type="checkbox"/> 7 YEARS <input type="checkbox"/> 8 YEARS <input type="checkbox"/> 9 YEARS <input type="checkbox"/> 10 YEARS <input type="checkbox"/> 11 YEARS <input type="checkbox"/> 12 YEARS <input type="checkbox"/> 13 YEARS <input type="checkbox"/> 14 YEARS <input type="checkbox"/> 15 YEARS <input type="checkbox"/> 16 YEARS <input type="checkbox"/> 17 YEARS <input type="checkbox"/> 18 YEARS <input type="checkbox"/> 19 YEARS <input type="checkbox"/> 20 YEARS <input type="checkbox"/> 21 YEARS <input type="checkbox"/> 22 YEARS <input type="checkbox"/> 23 YEARS <input type="checkbox"/> 24 YEARS <input type="checkbox"/> 25 YEARS <input type="checkbox"/> 26 YEARS <input type="checkbox"/> 27 YEARS <input type="checkbox"/> 28 YEARS <input type="checkbox"/> 29 YEARS <input type="checkbox"/> 30 YEARS <input type="checkbox"/> 31 YEARS <input type="checkbox"/> 32 YEARS <input type="checkbox"/> 33 YEARS <input type="checkbox"/> 34 YEARS <input type="checkbox"/> 35 YEARS <input type="checkbox"/> 36 YEARS <input type="checkbox"/> 37 YEARS <input type="checkbox"/> 38 YEARS <input type="checkbox"/> 39 YEARS <input type="checkbox"/> 40 YEARS <input type="checkbox"/> 41 YEARS <input type="checkbox"/> 42 YEARS <input type="checkbox"/> 43 YEARS <input type="checkbox"/> 44 YEARS <input type="checkbox"/> 45 YEARS <input type="checkbox"/> 46 YEARS <input type="checkbox"/> 47 YEARS <input type="checkbox"/> 48 YEARS <input type="checkbox"/> 49 YEARS <input type="checkbox"/> 50 YEARS <input type="checkbox"/> 51 YEARS <input type="checkbox"/> 52 YEARS <input type="checkbox"/> 53 YEARS <input type="checkbox"/> 54 YEARS <input type="checkbox"/> 55 YEARS <input type="checkbox"/> 56 YEARS <input type="checkbox"/> 57 YEARS <input type="checkbox"/> 58 YEARS <input type="checkbox"/> 59 YEARS <input type="checkbox"/> 60 YEARS <input type="checkbox"/> 61 YEARS <input type="checkbox"/> 62 YEARS <input type="checkbox"/> 63 YEARS <input type="checkbox"/> 64 YEARS <input type="checkbox"/> 65 YEARS <input type="checkbox"/> 66 YEARS <input type="checkbox"/> 67 YEARS <input type="checkbox"/> 68 YEARS <input type="checkbox"/> 69 YEARS <input type="checkbox"/> 70 YEARS <input type="checkbox"/> 71 YEARS <input type="checkbox"/> 72 YEARS <input type="checkbox"/> 73 YEARS <input type="checkbox"/> 74 YEARS <input type="checkbox"/> 75 YEARS <input type="checkbox"/> 76 YEARS <input type="checkbox"/> 77 YEARS <input type="checkbox"/> 78 YEARS <input type="checkbox"/> 79 YEARS <input type="checkbox"/> 80 YEARS <input type="checkbox"/> 81 YEARS <input type="checkbox"/> 82 YEARS <input type="checkbox"/> 83 YEARS <input type="checkbox"/> 84 YEARS <input type="checkbox"/> 85 YEARS <input type="checkbox"/> 86 YEARS <input type="checkbox"/> 87 YEARS <input type="checkbox"/> 88 YEARS <input type="checkbox"/> 89 YEARS <input type="checkbox"/> 90 YEARS <input type="checkbox"/> 91 YEARS <input type="checkbox"/> 92 YEARS <input type="checkbox"/> 93 YEARS <input type="checkbox"/> 94 YEARS <input type="checkbox"/> 95 YEARS <input type="checkbox"/> 96 YEARS <input type="checkbox"/> 97 YEARS <input type="checkbox"/> 98 YEARS <input type="checkbox"/> 99 YEARS <input type="checkbox"/> 100 YEARS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printer</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-24-2569</u>	
17. INFORMANT <u>Austin F Pohl</u>		Address <u>4903 71st Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <u>Stroke</u>			
DUE TO (b) <u>Cerebral arteriosclerosis</u>			
DUE TO (c) <u>3 days prior to admission</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-27-1965</u> , 19 <u>65</u> , to <u>May 16, 1967</u> that (I) (we) last saw the deceased alive on <u>5/13/1967</u> and that death occurred at <u>11:30 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Leon R. Levitsky</u>		22b. DATE SIGNED <u>5/16/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Leon R. Levitsky</u>		22d. ADDRESS <u>3408 R.I. Ave 44t Rainier, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5.20.67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor, Md</u>
24. FUNERAL DIRECTOR <u>Lee Funeral Home</u>		25. RECORD BY REGISTRAR <u>19 1967</u>	
ADDRESS <u>300.4th st N E D C</u>		25a. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in all cases within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

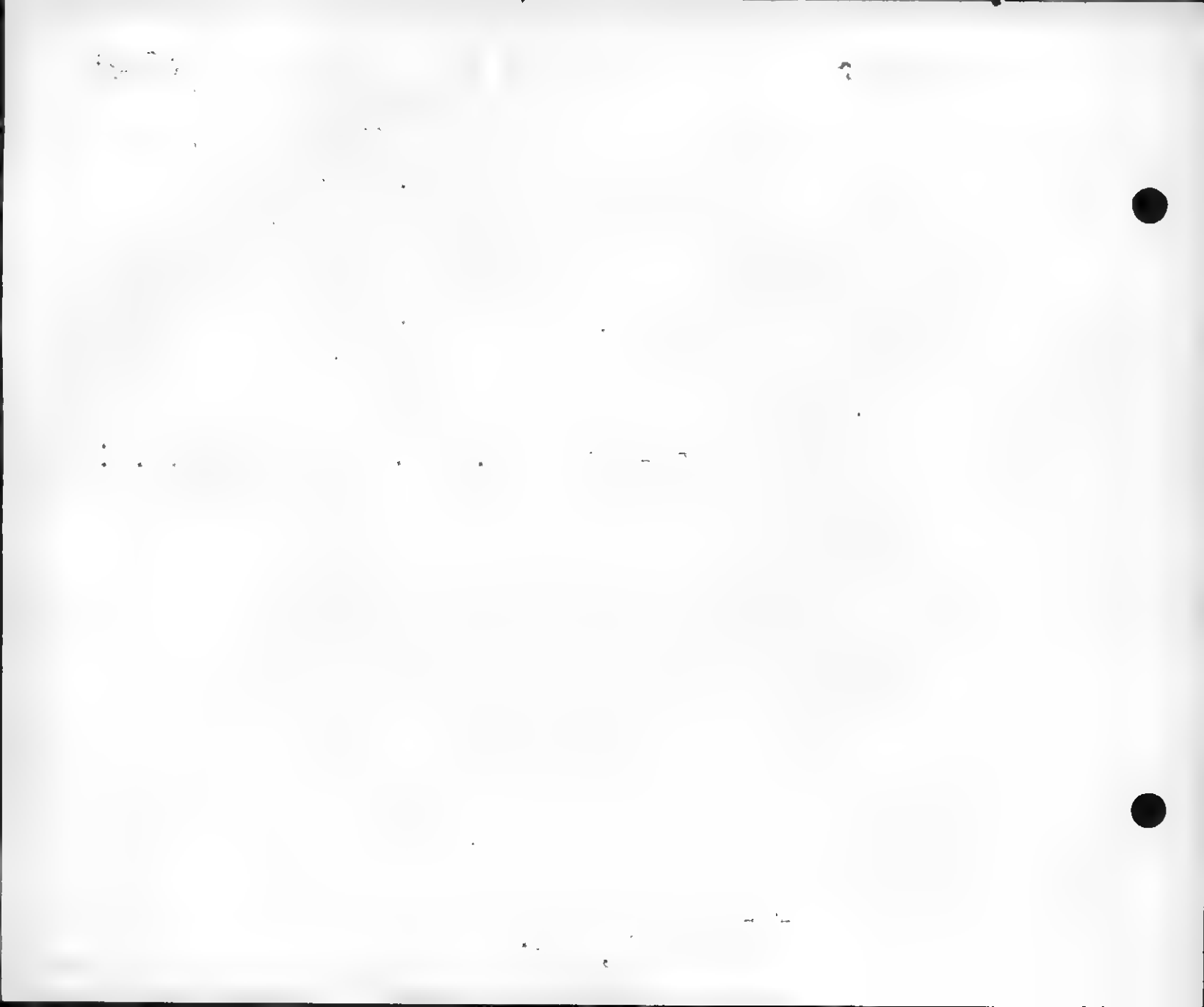
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07171

CERTIFICATE OF DEATH

07150

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mr. Rainier 1601		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges General Hospital			d. STREET ADDRESS 3402 Bunker Hill Rd/		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Clvde Middle P Last Pulley			4. DATE OF DEATH Month May Day 21 Year 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 Dec., 1924	9. AGE (In years last birthday) 42 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED		11. BIRTHPLACE (County & State, or foreign country) NORTH CAROLINA	
13. FATHER'S NAME JAMES R. PULLEY			14. MOTHER'S MAIDEN NAME STELLA EATMON		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 241-30-8140		17. INFORMANT Mrs. Faye K. Pulley Address 715 Edmund St. Raleigh, N. C. Wife	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute pancreatitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (the) this hospital attended the deceased from May 19, 1967 , to May 21, 1967 , that (the) we last saw the deceased alive on May 21, 1967 , and that death occurred 10:00 PM from causes and on the date stated above.					
22a. SIGNATURE T. J. Hernandez MD			22b. DATE SIGNED 5/22/67		22c. PHYSICIAN'S NAME (Type) T. J. Hernandez MD
22d. ADDRESS PGG H					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-24-67	23c. NAME OF CEMETERY OR CREMATORY OAKWOOD		23d. LOCATION (City or Town) (County) (State) RALEIGH, NORTH CAROLINA	
24. FUNERAL DIRECTOR GASCH'S		25a. REC'D BY REGISTRAR MAY 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07172

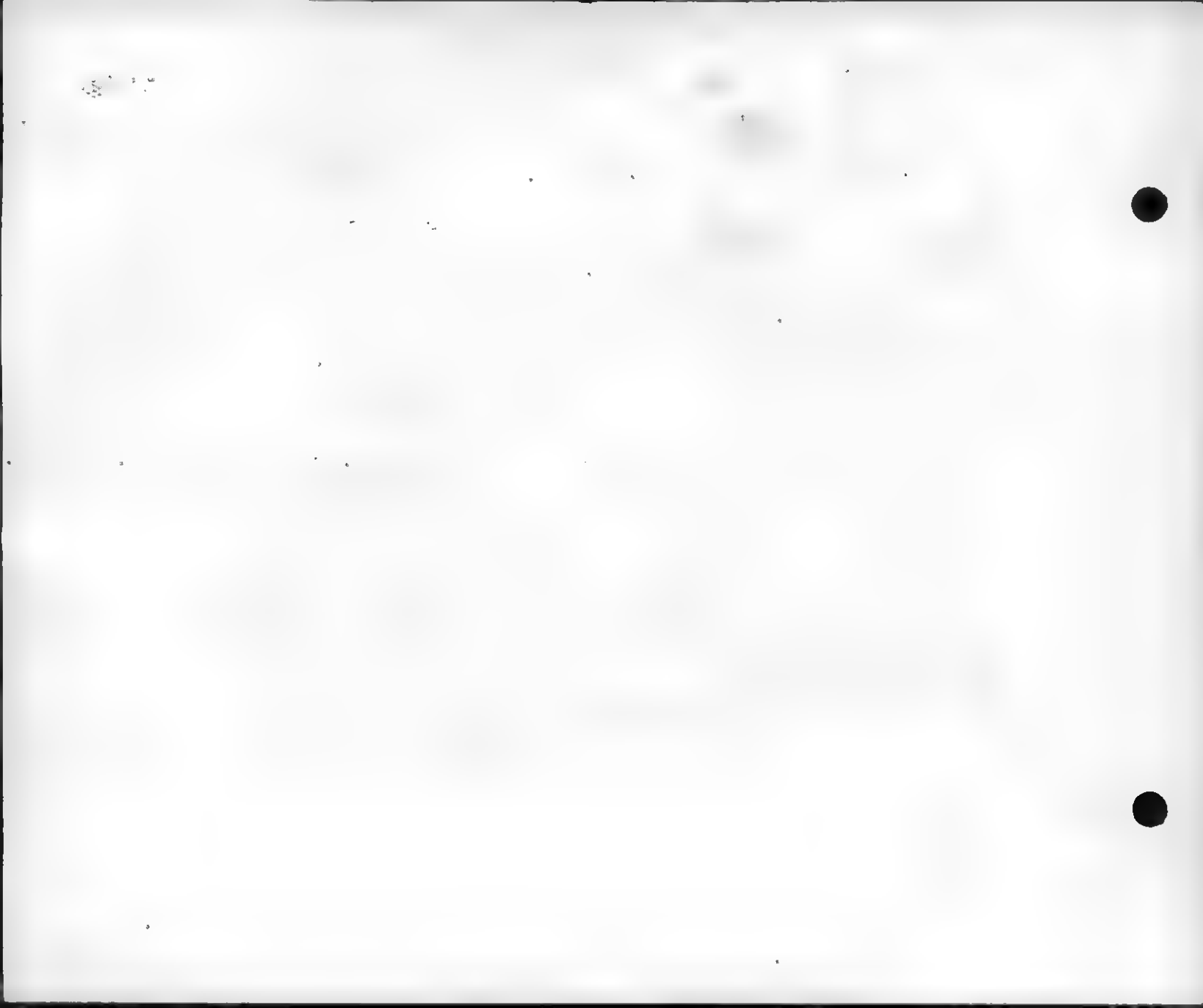
CERTIFICATE OF DEATH

07151

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 3 1/2 hrs.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE /Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover d. STREET ADDRESS 9109 Utica Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle S. Last Pumphrey		4. DATE OF DEATH Month May Day 27 Year 19 67	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-24-02
9. AGE (In years last birthday) 65 yrs		10. IF UNDER 1 YEAR Months 6 Days 15 Hours 15 Min.	11. IF UNDER 24 HRS. Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coppersmith		10b. KIND OF BUSINESS OR INDUSTRY Navy Yard	
11. BIRTHPLACE (County & State, or foreign country) Wash., D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clifford Pumphrey		14. MOTHER'S MAIDEN NAME Alice Spencer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-44-3706	
17. INFORMANT Mrs. Edna M. Orr - Sister		Address 4011-Ogle-thorpe St., Hy., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cerebral Hemorrhage DUE TO (b) Hypertensive cardiovascular disease DUE TO (c) chronic glomerular nephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary artery disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5-5-67 , to 5-27-67 , that (I) (we) last saw the deceased alive on 5-27-67 , and that death occurred at 7:15 M, from causes and on the date stated above.			
22a. SIGNATURE George Hageage		22b. DATE SIGNED 5-27-67	
22c. PHYSICIAN'S NAME (Type) George Hageage		22d. ADDRESS 3717-38th Cottage City Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/31/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	23d. LOCATION (City or Town) (County) (State) Suitland, Md.
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a. REC'D BY REGISTRAR DATE JUN 2 1967	
ADDRESS Mt. Rainier Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 21 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



VR A15 (4)
20 M 1/66

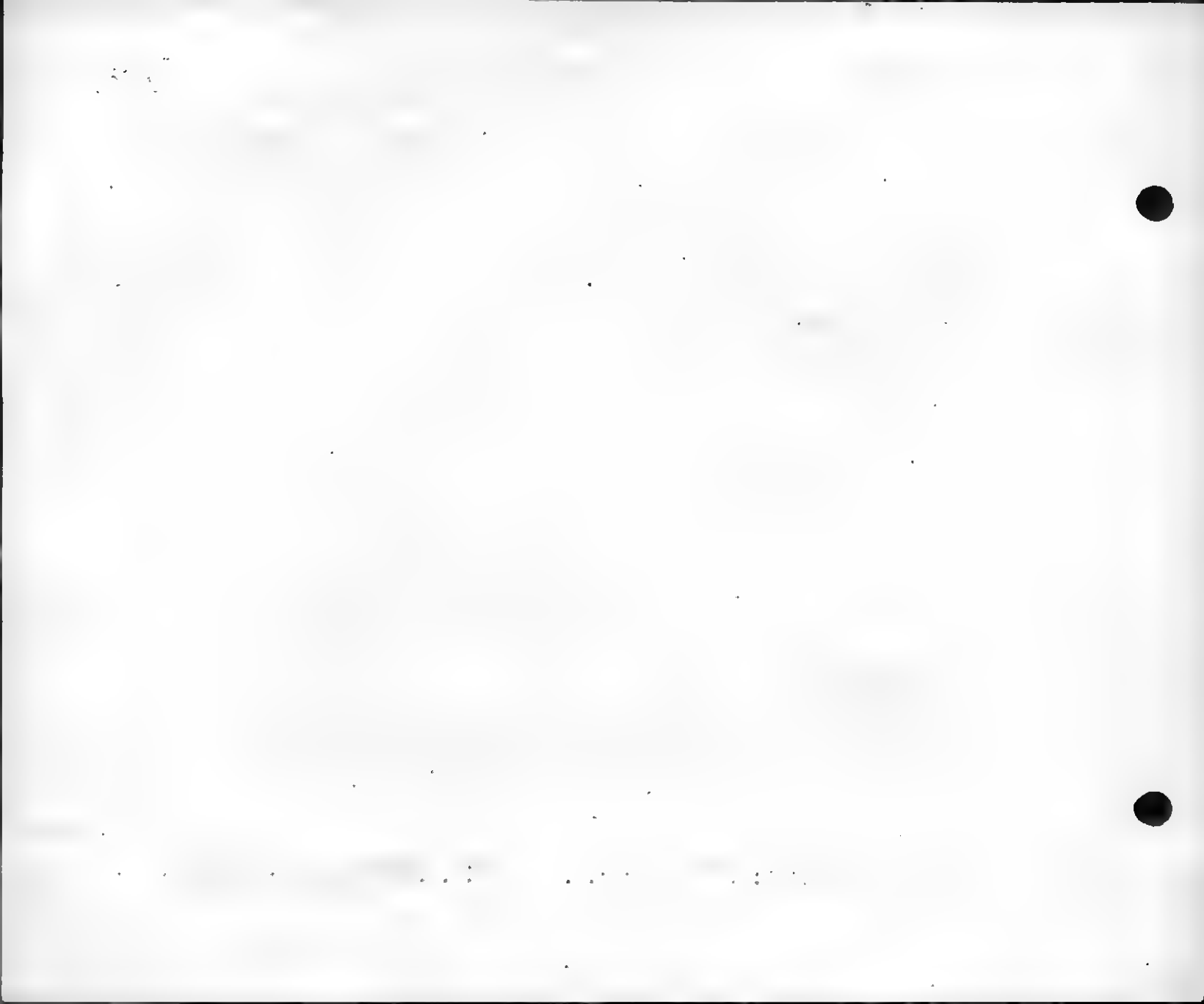
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07173

CERTIFICATE OF DEATH

07152

1 PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 7-1/2 days		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS Cape Anne		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) FREDERICK Fredrick H. Purschwitz		4. DATE OF DEATH Month May Day 12 Year 1967			
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 10/9/05	9. AGE (In years last birthday) 61 yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TECHNICIAN		10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURAL DEPT US		11 BIRTHPLACE (County & State, or foreign country) WISCONSIN	
13 FATHER'S NAME HENRY PURSCHWITZ		14 MOTHER'S MAIDEN NAME ANNIE RAU			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 215447877		17. INFORMANT ROSALIE PURSCHWITZ Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOCK DUE TO ACUTE HEMORRHAGIC PANCREATITIS DUE TO ACUTE PENETRATING GASTRIC ULCER WITH HEMORRHAIGE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (the hospital) attended the deceased from May 3, 1967 to May 12, 1967 , that (I) (we) last saw the deceased alive on May 12, 1967 , and that death occurred at 6:45 M , from causes and on the date stated above.					
22a. SIGNATURE 		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 12, 1967	
22c. PHYSICIAN'S NAME (Type) Robert B. G. Sasser, M.D.		22d. ADDRESS R. F. D 2150, Upper Marlboro, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MAY 15, 1967	23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY		23d. LOCATION (City or Town) (County) (State) BLADENSBURG, MARYLAND	
24. FUNERAL DIRECTOR W. W. CHAMBERS, Co. RIVERDALE, MARYLAND		25a. REC'D BY REGISTRAR DATE MAY 18 1967		25b. REGISTRAR'S SIGNATURE 	



FOR STATE
HEALTH DEPT.)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

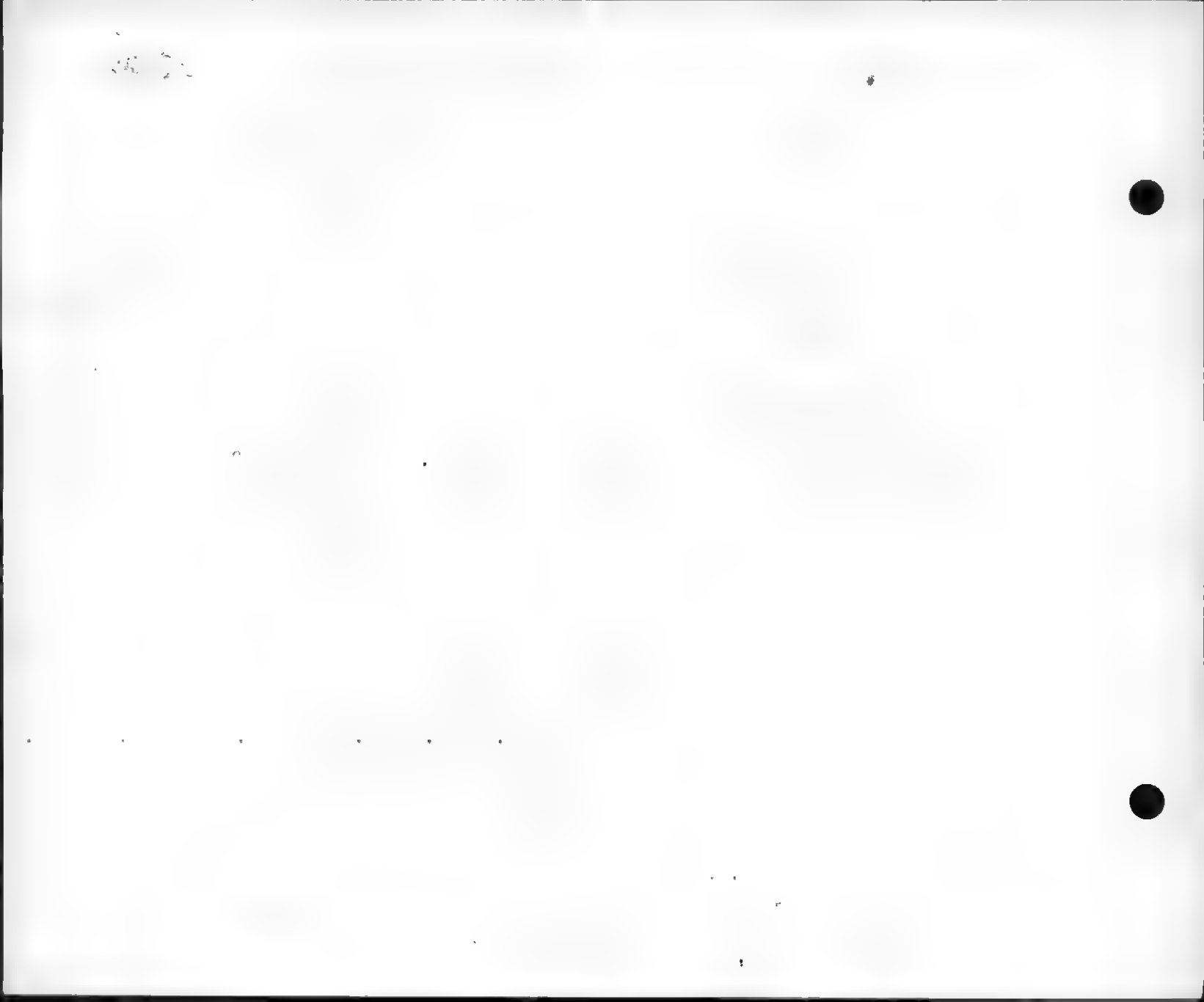
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07174

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07153

1 PLACE OF DEATH a. COUNTY Prince George's MARY. AND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN IB eight hours			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's General Hospital				e. STREET ADDRESS 1114 Huron Drive			
NAME OF DECEASED (Type or print) First Middle Last Jackie William Ray				4 DATE OF DEATH Month Day Year 5 26 19 67			
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4-4-32	9 AGE (In years last birthday) 35 yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11 BIRTHPLACE (State or foreign country) Indiana		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Grant Sherman Ray				14 MOTHER'S MAIDEN NAME Ruth C. Carson			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16 SOCIAL SECURITY NO None		17 INFORMANT Address Grant S. Ray Same As #2			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laceration of brain 5124 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Multiple Skull Fractures (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Pedestrian struck by car					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 8:08am 5-26 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, factory, street, office, etc.) Balt.-Wash. Pkwy.		20f. (City or town) (County) (State) near Rte. 495, P.G., Md.	
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address: (Street, city, town, or county) 11th St. S.E. Suitland Maryland					
23a. BURIAL CREMATION Burial		23b. DATE THEREOF 6/1/67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or town) (County) (State) Suitland Maryland	
24 FUNERAL DIRECTOR W.W. Chambers, Co. Inc. Washington, D.C.				25a. REC'D BY REGISTRAR JUN 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07175

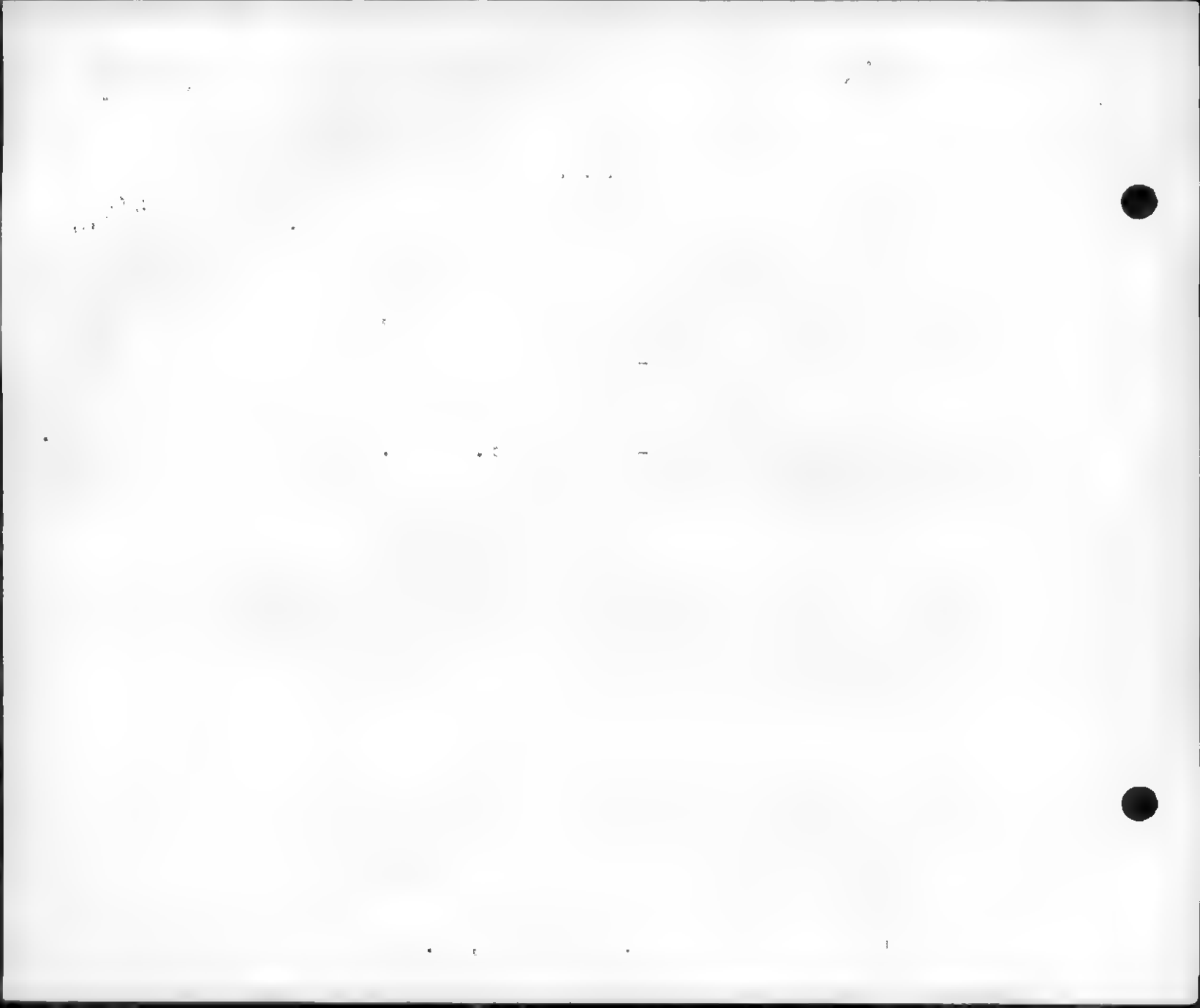
CERTIFICATE OF DEATH

07154

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUITLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RAIDENT HALL	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5103 MARLBORO PIKE		d. STREET ADDRESS 6713 MUNSEY ST.	
3. NAME OF DECEASED (Type or print) First John Middle Elmer Last Rayford		4. DATE OF DEATH Month May Day 23 Year 1967	
5. SEX Male	6. COLOR OR RACE Ca.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 22, 1874
9. AGE (In years last birthday) 93 yrs		10. UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	11. UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mathew Rayford		14. MOTHER'S MAIDEN NAME Catherine Carr	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 579-50-9334	
17. INFORMANT Mrs. Elmer E. Rayford		Address 373 Edgewater Rd. Pasadena, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO CARDIAC ARREST (b) Myocardial Inficiency DUE TO Myocardial Inficiency (c) Myocardial Inficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Myocardial Inficiency PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS			INTERVAL BETWEEN ONSET AND DEATH 10 min 30 min 4-5 hr
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/18 , 19 66 , to May 23, 1967 , that (I) (we) last saw the deceased alive on May 23, 1967 , and that death occurred at 6 p.m. from causes and on the date stated above.			
22a. SIGNATURE Thomas F. Cullen		22b. DATE SIGNED 23 May 67	22c. PHYSICIAN'S NAME (Type) Thomas F. Cullen
22d. ADDRESS 5103 Marlboro Pike		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-26-67	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL	23d. LOCATION (City or Town) (County) (State) SUITLAND MARYLAND
24. FUNERAL DIRECTOR GASCH'S		25a. REC'D BY REGISTRAR 4739 Baltimore Ave. Hyattsville, Md.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAY 26 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

97176

CERTIFICATE OF DEATH

07155

1 PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>11 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General</u>		d. STREET ADDRESS <u>4307 39th Place</u>	
3. NAME OF DECEASED (Type or print) <u>ADALON B. Reynolds</u>		4. DATE OF DEATH Month <u>May</u> Day <u>27</u> Year <u>1967</u>	
5 SEX <u>P</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4-5-15</u>
9 AGE (In years lost birthday) <u>52</u> yrs.		10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Lynchburg, Va.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Clarkson</u>	
14. MOTHER'S MAIDEN NAME <u>Susie Roberts</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO <u>577-05-8939</u>		17. INFORMANT <u>Mrs. Barbara Holtzclaw</u> Address <u>3500-Dean Dr.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia (daughter)</u> <u>terminal</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>subarachnoid hemorrhage</u> <u>acute</u> DUE TO (c) <u>Chronic Pyelonephritis</u> <u>5 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5 yrs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 11, 1967</u> to <u>May 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 27, 1967</u> , and that death occurred at <u>9:55 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Benjamin L. Mueller</u>		22b. DATE SIGNED <u>28 May 1967</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL (CREMATION, REMOVAL (Specify)) <u>Burial</u>	23b. DATE THEREOF <u>5/31/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor, Md.</u>
24. FUNERAL DIRECTOR <u>Valley's Funeral Home Inc.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 2 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

VR A15 (4)
20 M 1/66

0245

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO MEDICAL EXAMINER: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 48 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
37177 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07156

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr Geo	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel	
c. LENGTH OF STAY IN 1b DoA		d. STREET ADDRESS RT 2 Lumpowdermill Rd	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) ALMA Inez	First ALMA Middle Inez Last RICE	4. DATE OF DEATH May 22 1967	Month May Day 22 Year 1967
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30 1922
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months 4 Days 15 Hours 15 Min.	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. PLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME William A. Price		14. MOTHER'S MAIDEN NAME Mary Leasure	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. no	
17. INFORMANT Pr Geo Police		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Confusions & Lacerations of Brain - Gunshot inst. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Wound DUE TO (c) Wound	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Subject has had mental treatment Post Sural and		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Subject Shot Self in head	
20c. TIME OF INJURY Month, Day, Year May 22 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Laurel (County) Pr Geo (State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dayton O Watkins		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) DAYTON O. WATKINS		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) 6318 Annapolis Rd, Beltsville, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5-26-67	23c. NAME OF CEMETERY OR CREMATORY Greenmount	23d. LOCATION (City, town or county) Cumberland Maryland
24. FUNERAL DIRECTOR GASCH'S		25a. REC'D BY REGISTRAR May 26 1967	
ADDRESS 4739 Baltimore Ave. Hyattsville, Maryland		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

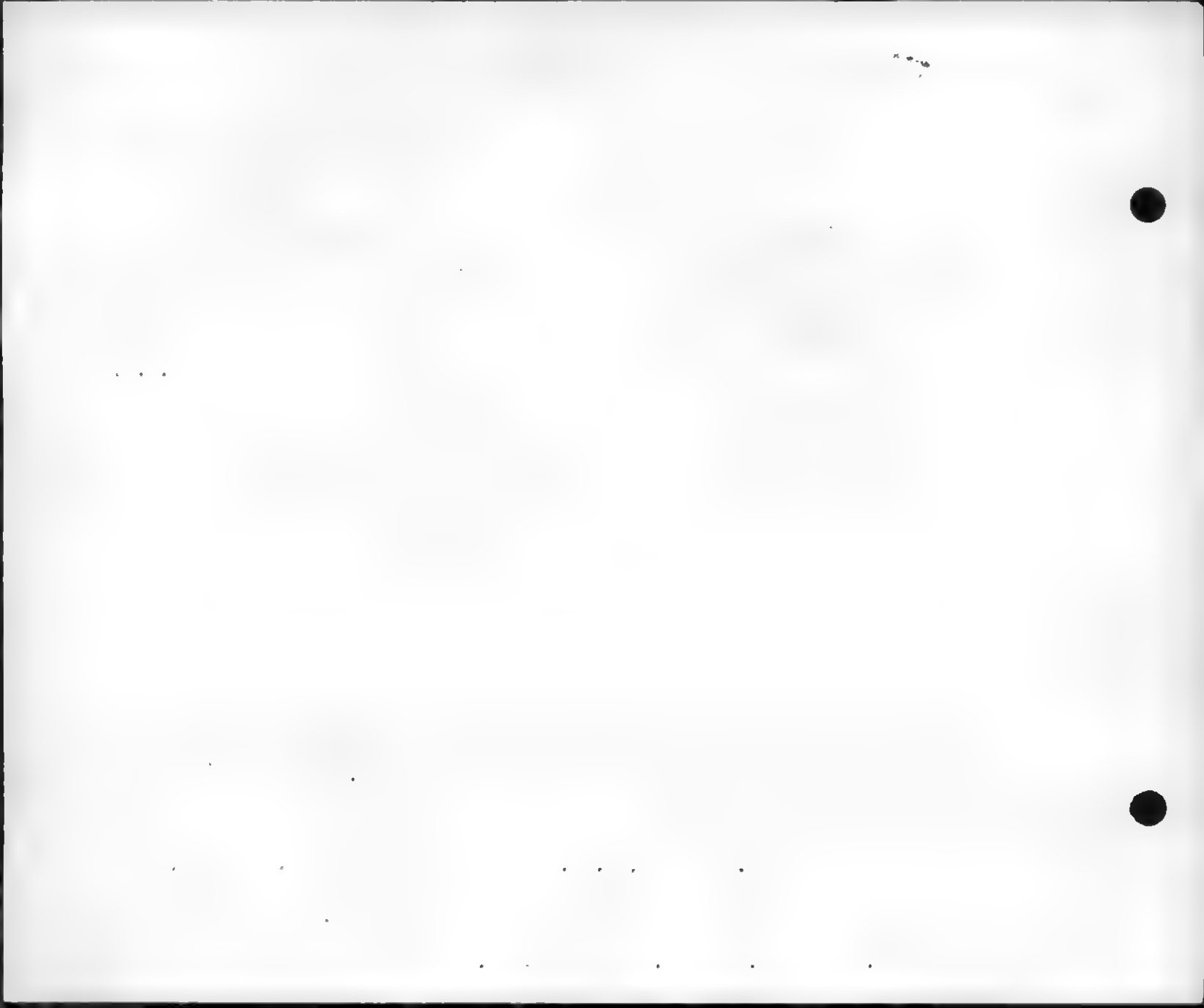
07178

CERTIFICATE OF DEATH

08634

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 12 min		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 7815 Valley Park Road		
3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last Richards			4. DATE OF DEATH Month May Day 31 Year 19 67		
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 31 May 1967	9 AGE (In years last birthday) yrs	IF UNDER 1 YEAR Months Days Hours Min 12
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Maryland	
13 FATHER'S NAME William E		14. MOTHER'S MAIDEN NAME Sonja Marie			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16 SOCIAL SECURITY NO		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7610 Fetal asphyxia DUE TO (b) Abrupted Placenta Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from May 31, 1967 to May 31, 1967 , that (I) (we) last saw the deceased alive on May 31, 1967 , and that death occurred at 1.40AM from causes on and on the date stated above.					
22a SIGNATURE Joseph A. Murgalo			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) Joseph A. Murgalo, M. D.			22d ADDRESS 5813 Landover Rd. Cheverly, Maryland		
23a BURIAL, CREMATION, REMOVA. (Specify) Cremation	23b DATE THEREOF 6/10/67	23c NAME OF CEMETERY OR CREMATORY Prince George's General Hqsp., Cheverly		23d LOCATION (City or Town) (County) (State) PG Maryland	
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Admin., Cheverly, Md.			25. REG'D BY REGISTRAR JUN 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07157

07173

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Res dence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City	
d. NAME OF HOSPITAL (If not in hospital, give street address) 4110 Cottage Terrace		d. STREET ADDRESS 4110 Cottage Terrace	
3. NAME OF DECEASED (Type or print) First HAMILTON Middle ROBERT Last SAGO		4. DATE OF DEATH Month May Day 3 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 16, 1890
9. AGE (In years last birthday) yrs. 76		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanical Engineer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Government	11. BIRTHPLACE (State or foreign country) Indiana
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John Sago	
14. MOTHER'S MAIDEN NAME Daisy O. Greene		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Year, if unknown) (If yes, give war or dates of service) Unk.	
16. SOCIAL SECURITY NO. 234 01 5846		INFORMANT Audrey F. Sago Same as #2 (wife)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pul. Embolism 5271 DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Emphysema DUE TO (c) allergic bronchitis			INTERVAL BETWEEN ONSET AND DEATH 5-3-67 1957.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7-29 to 5-3 , that I last saw the deceased alive on 5-3 , and that death occurred at 8:30 P. M. from the causes and on the date stated above			
ACTUAL SIGNATURE George H. Gage		ADDRESS (Street, city or town, state) 3717-38th Ave	
PHYSICIAN'S NAME (Type) Cottage City Md		DATE SIGNED 5-3-67	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/8/67	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	22d. LOCATION (City, town, or county) (State) Colmar Manor P. G. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR MAY 8 1967		24b. REGISTRAR'S SIGNATURE Charles Judge	



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

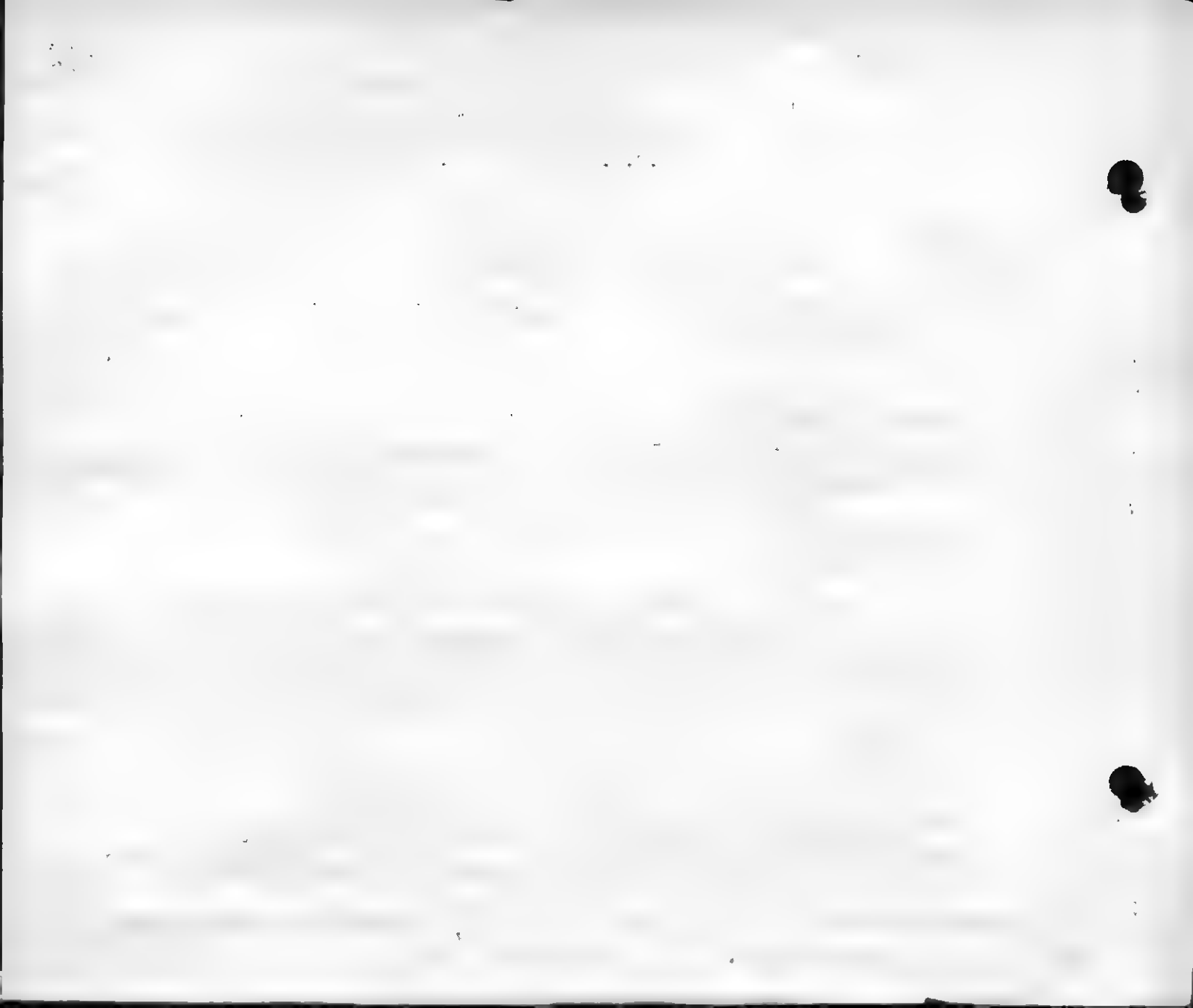
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07180

07158

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mt. Rainier d. STREET ADDRESS 3307 Chillum Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Clark Sawyers		4. DATE OF DEATH Month May Day 20 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 2, 1911
9. AGE (In years last birthday) 55 56 yrs.		10. IF UNDER 1 YEAR Months 5 Days 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James T. Sawyers		14. MOTHER'S MAIDEN NAME Ada Phillips	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 372-16-2427	
17. INFORMANT Evelyn Sawyers (Wife)		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SUBACUTE GLOMERULONEPHRITIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ACUTE PSEUDOMEMBRANOUS TRACHEITIS			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Cornelius J. Burns M.D. EXAMINER'S NAME (Type) Cornelius J. Burns, MD CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> (Acting) Address (Street, city, town, or county) Cheverly, Maryland DATE SIGNED May 20, 1967			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/23/67	
22c. NAME OF CEMETERY OR CREMATORY Baltimore Nat. Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR Valley's Funeral Home Inc.		24. ADDRESS Mt. Rainier, Maryland	
25. DATE OF REGISTRATION MAY 24 1967		26. REGISTRAR'S SIGNATURE Charles Judge	

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director for Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07159

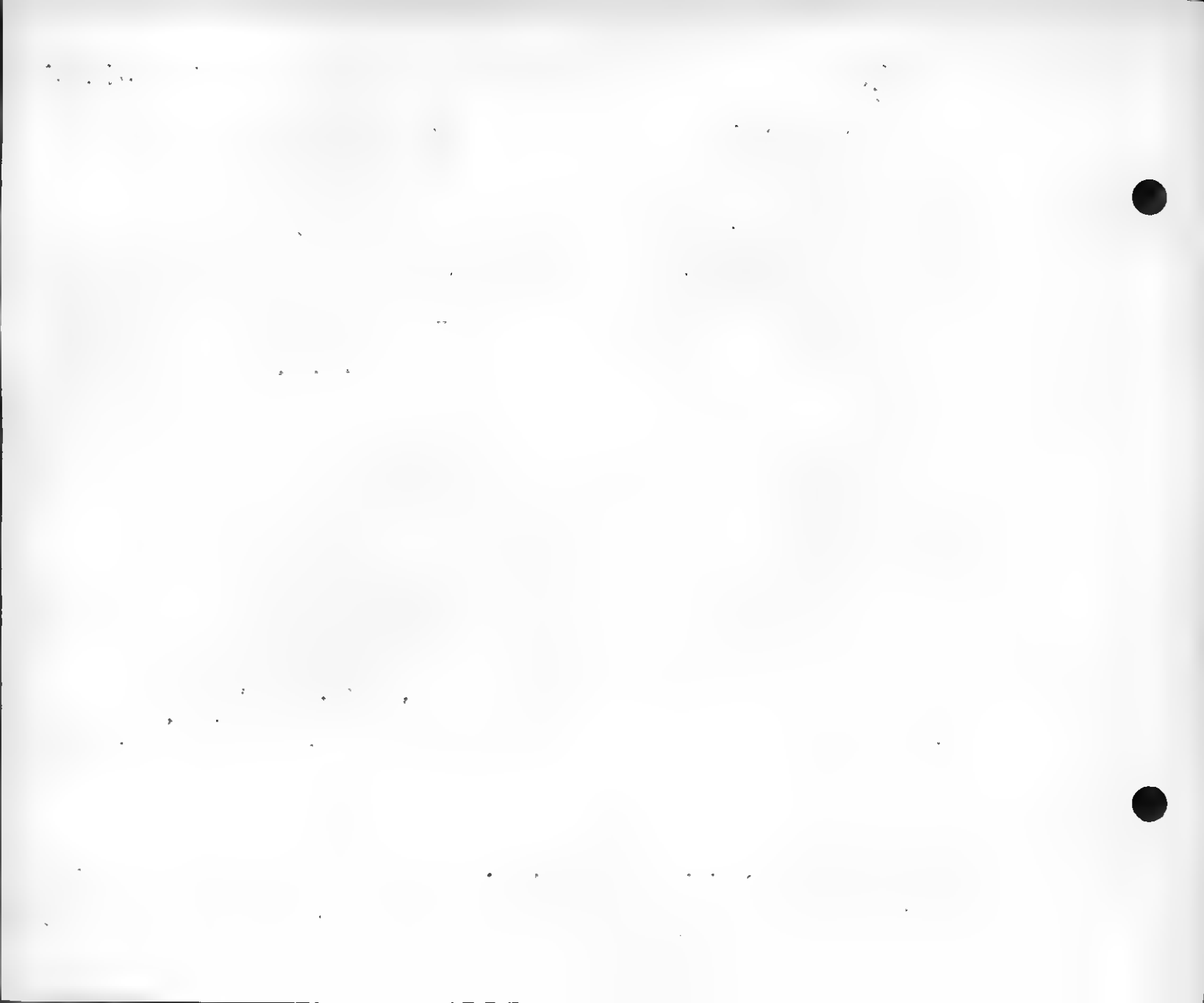
07181

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 4504 Payne Drive	
3. NAME OF DECEASED (Type or print) Alexander		4. DATE OF DEATH Month 5 Day 19 Year 1967	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-19-1890
9. AGE (in years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Florest	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Alice ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO	
17. INFORMANT Emma Sharper		Address Same As # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gun shot wound of brain DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Shot self in head with .35 cal. revolver	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 7:30am p.m. 5-19-67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Abandoned greenhouse, 6452 Lanham La., Camp Springs, Md.		20f. (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		22. DATE SIGNED 5-19-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street, city, town or county) Riverdale, Md.	
23a. BURIAL (CREMATION, REMOVAL) (Specify) Burial	23b. DATE THEREOF 22 May 1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland, Prince Georges, Md
24. FUNERAL DIRECTOR Wilhelm Funeral Home ADDRESS 4308 Suitland Road, Suitland, Maryland			
25. REGISTRY REGISTRAR DATE MAY 22 1967		25. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <div>10</div> <div>1</div> </div> <div> <div>MD</div> <div>07182</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> <div>07160</div> </div> </div>											
1. PLACE OF DEATH a. COUNTY Prince George				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt				c. LENGTH OF STAY IN lb 4 mos.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 125 - Hedgewood Drive				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland				b. COUNTY Garrett			
3. NAME OF DECEASED (Type or print) First Middle Last Virgie E. Shaver				4. DATE OF DEATH Month Day Year May 21 19 67				6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/14/1909		9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Garment Mfg.				11. BIRTHPLACE (County & State, or foreign country) Maryland			
13. FATHER'S NAME Harry Upole				14. MOTHER'S MAIDEN NAME Maude Lambert				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO.				17. INFORMANT George Shaver- (Son)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic Carcinoma</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Carcinoma of breast</i> DUE TO (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i> <i>3 years</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>3-22-67</i> , 19 <i>67</i> , to <i>5-21-</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>5/6/67</i> 19 <i>67</i> , and that death occurred at <i>10 P</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>John J. Hughes</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <i>5-22-67</i>			
22c. PHYSICIAN'S NAME (Type) <i>John J. Hughes</i>				22d. ADDRESS <i>2141 - K St. N.W. Suite 503 Washington, D.C.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF <i>5/24/67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Vanverth Cem.</i>		23d. LOCATION (City, town or county) (State) <i>Freeport, W. Va.</i>			
24. FUNERAL DIRECTOR <i>Home Inc.</i>				ADDRESS <i>Nalley's Funeral Mt. Rainier Maryland</i>				25a. REC'D BY REGISTRAR <i>DATE MAY 25 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, removal, and in any event within 72 hours after death.

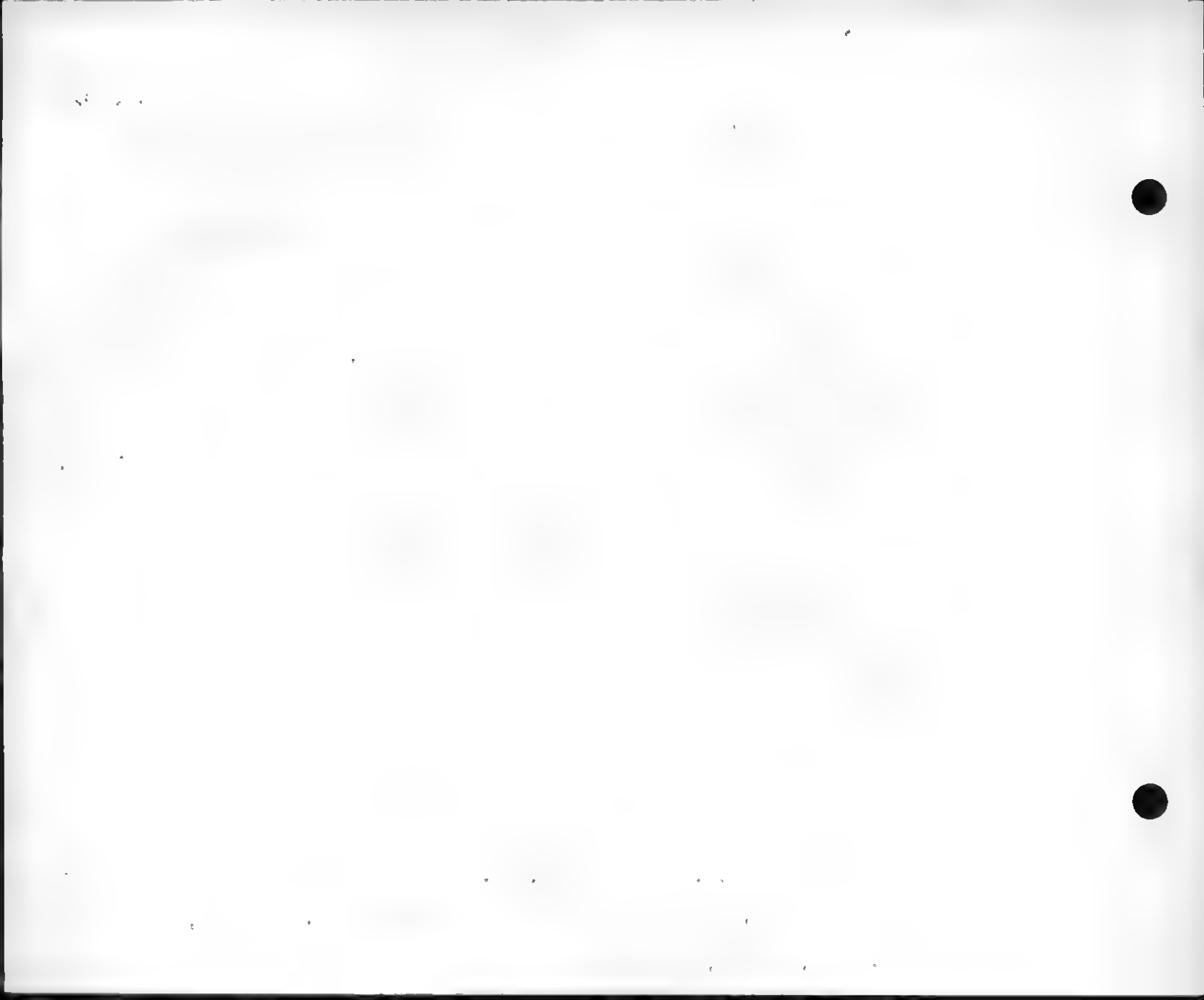
FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07183

07161

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly			c LENGTH OF STAY IN 1b DOA		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			e STREET ADDRESS 7311 District Heights Parkway		
3 NAME OF DECEASED (Type or print) JAMES Baby MICHAEL Boy Shoemaker			4 DATE OF DEATH 5 10 19 67		
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 1, 1967	9. AGE (In years lost birthday) yrs 9	F UNDER 1 Year Months 9 Days 9
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY - - -		11 BIRTHPLACE (State or foreign country) Takoma Park, Maryland
13 FATHER'S NAME Frank Shoemaker			14 MOTHER'S MAIDEN NAME Patricia Russell		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No			16 SOCIAL SECURITY NO N/A		17 INFORMANT Prince George County Welfare Board, Brantwood Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia DUE TO Aspiration of gastric contents Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Unknown DUE TO (c) Unknown					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Asphyxiated in crib after vomiting.			
20c TIME OF INJURY Month, Day, Year Hour:am. 8:00 p.m. 5-10-1967		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect on <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe M.D.			22. DATE SIGNED 5-11-67		
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.			Address (Street) city town or county		
23a BURIAL CREMATION (Specify) BURIAL	23b DATE THEREOF May 13, 1967	23c NAME OF CEMETERY OR CREMATORY Carver Memorial Cemetery, Rt. #1, Laurel, Maryland		23d LOCATION (City town) (County) (State)	
24 FUNERAL DIRECTOR Harold S. Wade, Laurel, Maryland			25c REC'D BY REGISTRAR MAY 19 1967 25d REGISTRAR'S SIGNATURE J. Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

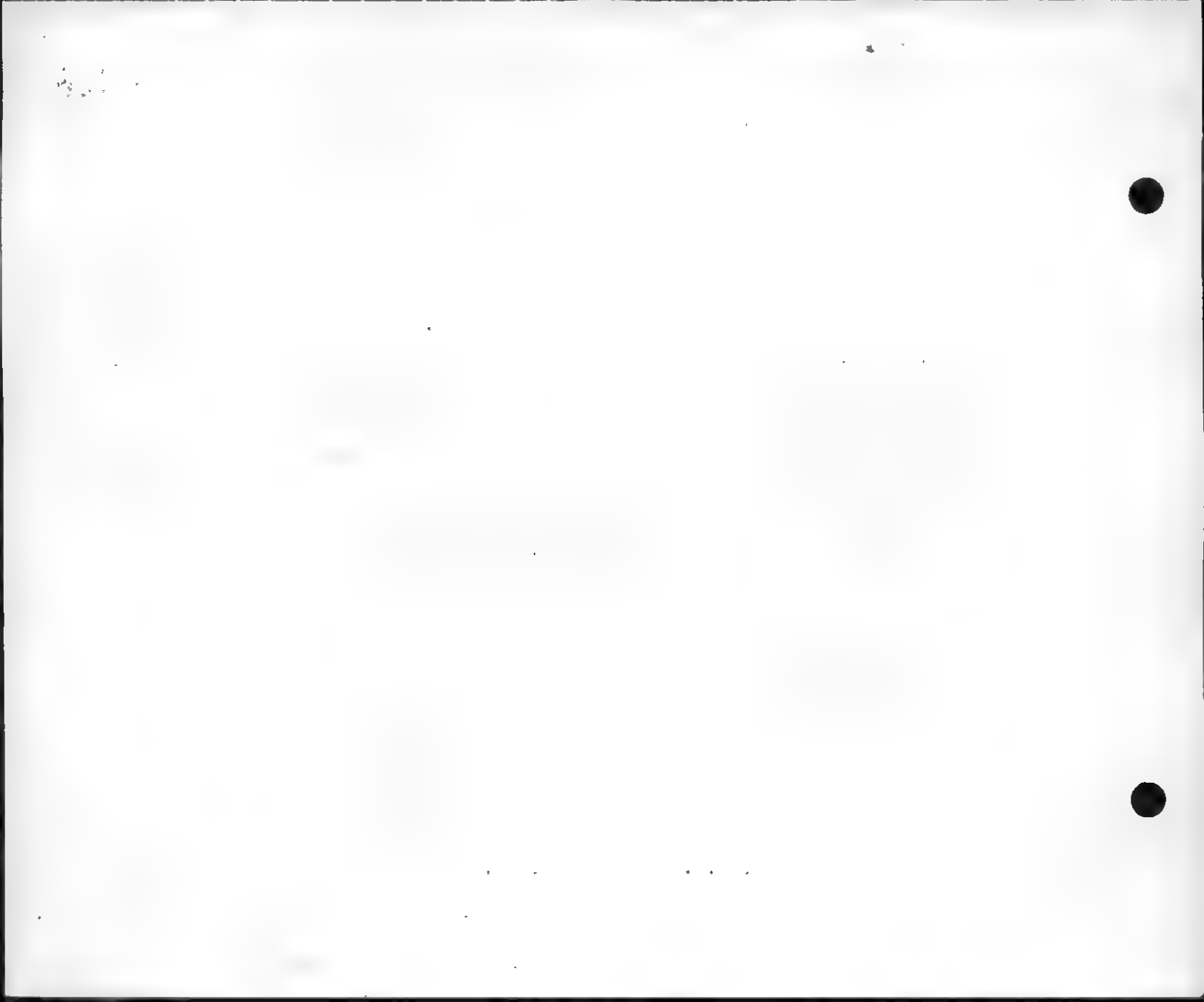
FOR STATE
HEALTH DEPT.

07184

07162

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Resident or long-term care) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. STREET ADDRESS 6402 Seabrook Road	
3 NAME OF DECEASED (Type or print) First Elbert Middle L Last Silvers		4 DATE OF DEATH Month 5 Day 1 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7 Jan. 1924
9 AGE (In years lost birthday) yrs 43		10 F UNDER 1 YEAR Months 1 Days 19 Hours 67	
10a USUAL OCCUPATION (Give kind of work done during most of time, even if retired) Lab. Tech.		10b KIND OF BUSINESS OR INDUSTRY U.S. Government	
11 BIRTHPLACE (State or foreign country) Georgia		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Charles Silvers		14 MOTHER'S MAIDEN NAME Beatrice Holder	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes, give year or dates at service) yes WWII		16 SOCIAL SECURITY NO	
17 INFORMANT A. Marie Silvers Same as #2 (wife)		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure 4201 DUE TO Coronary artery occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Atherosclerotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH minutes minutes unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, had an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22 DATE SIGNED 5-2-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town or county)	
23a BURIAL, CREMATION, REBURY (Specify)		23b DATE THEREOF	
Burial		5/5/67	
23c NAME OF CEMETERY OR CREMATORY Arlington National		23d LOCATION (City or town) (County) (State) Arlington, Arlington Va.	
24 FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a REC'D BY REGISTRAR MM 8 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			

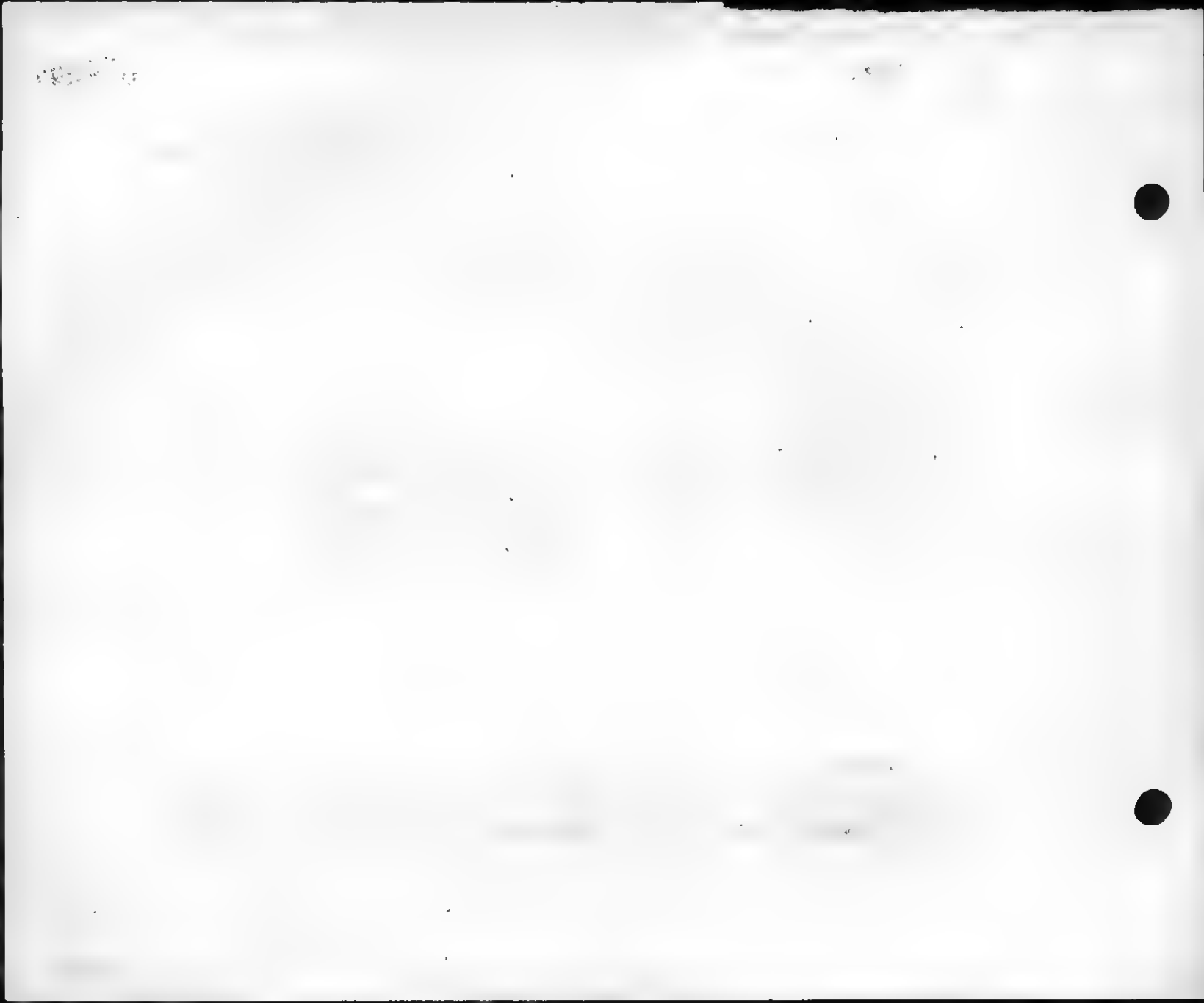
THIS COPY MUST BE EXAMINED: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil. Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, on in any event within 72 hours after death.



07163

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

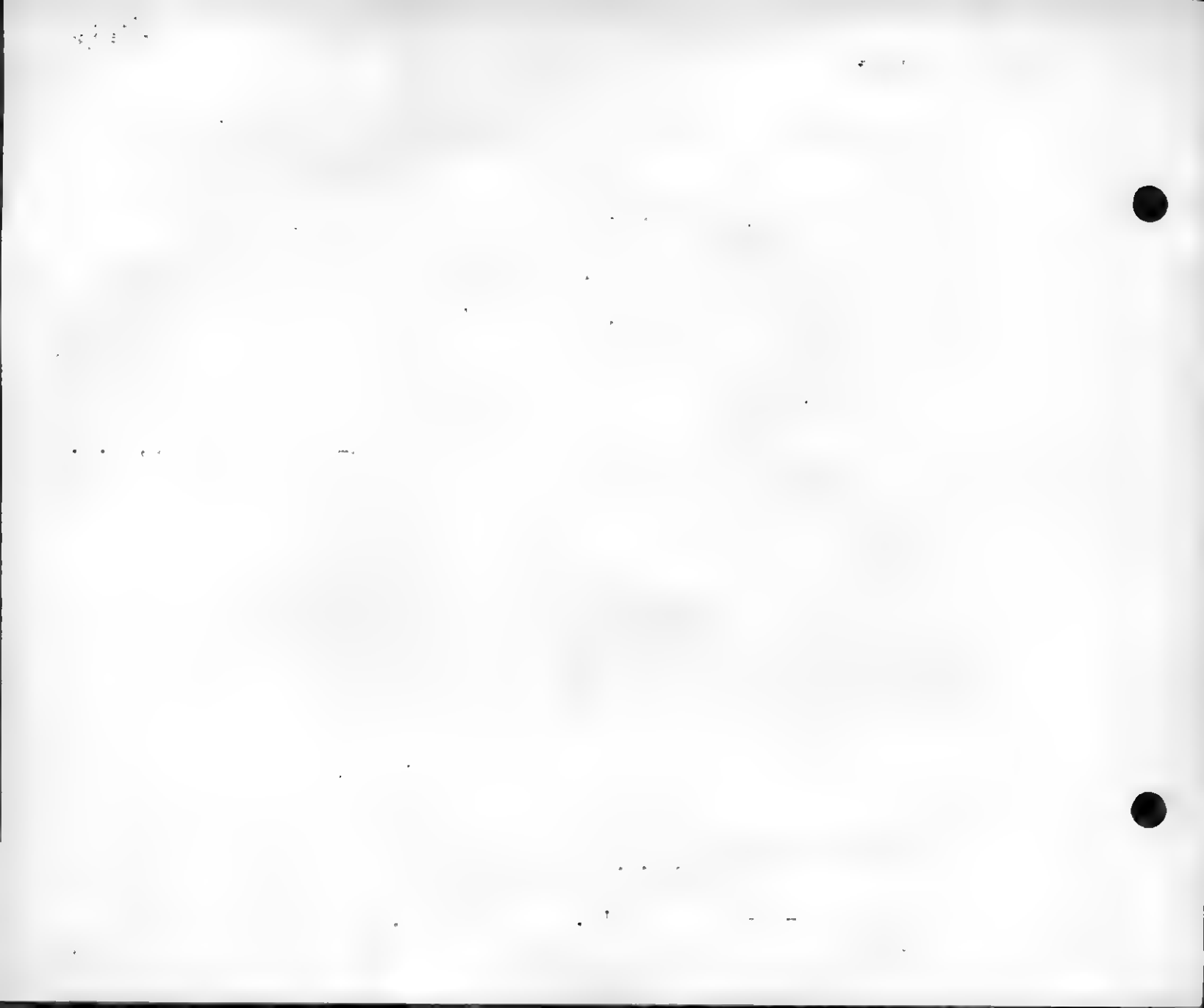
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07186

CERTIFICATE OF DEATH

07164

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 44 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General HOSpital			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Upper Marlboro d. STREET ADDRESS 8913 Cherry Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last John W. Simms			4. DATE OF DEATH Month Day Year May 9 1967		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/21/05	9. AGE (In years last birthday) 62 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Robert Simms		
14. MOTHER'S MAIDEN NAME Bessie Johnson			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16. SOCIAL SECURITY NO Unk.			17. INFORMANT Address Marilyn Jones-2215 Rand Pl., N.E.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident - embolic 42.01 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Myocardial Infarction DUE TO (c) Coronary Arteriosclerotic Heart Disease					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Corricular Fibrillation					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from March 26, 1967 , to May 9, 1967 , that he (we) last saw the deceased alive on May 9, 1967 , and that death occurred at 1 P.M. from causes and on the date stated above.					
22a. SIGNATURE Edwin Jensen M.D.			22b. DATE SIGNED May 9, 1967		22c. PHYSICIAN'S NAME (Type) Edwin Jensen, M.D.
22d. ADDRESS Prince Georges General Hospital		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF 5-13-67		23c. NAME OF CEMETERY OR CREMATORY Nat'l. Harmony Mem. Pk. Landover, Maryland		23d. LOCATION (City or town) (County) (State)	
24. FUNERAL DIRECTOR Rollins		25a. REC'D BY REGISTRAR H339 Hunt Pl N.E. WASH, D.C.		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE MAY 12 1967					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MD. 21201 CERTIFICATE OF DEATH </div>																					
1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>																
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN ID <u>11 Days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Heights,</u>																
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>74 Prince George General Hospital</u>					d. STREET ADDRESS <u>2577--Colebrooke Dr., SE</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>RUSSELL</u> Middle <u>H.</u> Last <u>STAINBACK</u>					4. DATE OF DEATH Month <u>MAY</u> Day <u>11th</u> Year <u>19 67</u>																
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 7th, 1912</u>		9. AGE (in years last birthday) <u>54</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.				
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Mechanic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Auto Mechanic</u>		11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>North Carolina</u>													
13. FATHER'S NAME <u>William R. Stainback</u>					14. MOTHER'S MAIDEN NAME <u>Lessie Hicks</u>																
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-20-0392</u>		17. INFORMANT Address <u>Bessie M. Stainback (Wife) Same as Item 12</u>																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> (b) <u>Phlebotrombosis</u> (c) <u>Cirrhosis of liver</u>								INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>days</u> <u>3 years</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Umbilical Vein catheterization</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)															
21. I certify that (I) (this hospital) attended the deceased from <u>May 1,</u> 19 <u>67</u> , to <u>May 11,</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 11,</u> 19 <u>67</u> , and that death occurred at <u>5:55 A.</u> M, from the causes and on the date stated above.																					
22a. SIGNATURE <u>John H. Bayly</u>					22b. DATE SIGNED <u>May 11-1967</u>																
22c. PHYSICIAN'S NAME (Type) <u>Dr. John H. Bayly</u>					22d. ADDRESS <u>1845--I--St., N. W., Wash. DC</u>																
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 13-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Bladensburg, Md.</u>															
24. FUNERAL DIRECTOR <u>Simmons Bros.</u>					25a. REC'D BY REGISTRAR <u>MAY 12 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>														



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

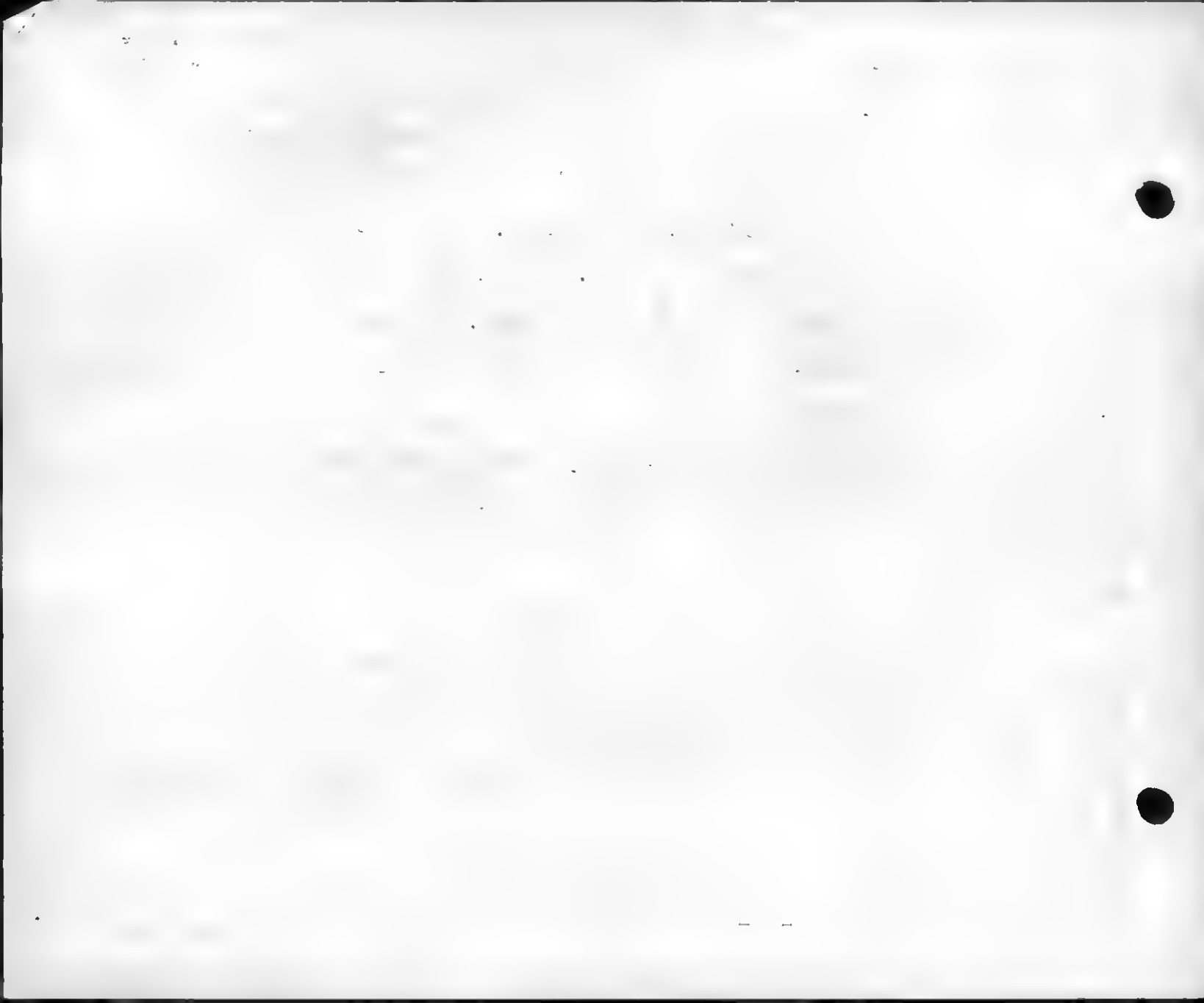
CERTIFICATE OF DEATH

07188

07166

1 PLACE OF DEATH a COUNTY Prince George MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE District of Columbia b. COUNTY ✓	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 6 years	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Home, 5805 Queens Chapel Rd.		d STREET ADDRESS 637 - 5th Street, N.E.	
3 NAME OF DECEASED (Type or print) First Middle Last Lola C. Starke		4. DATE OF DEATH Month Day Year May 14 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 11, 1882
9 AGE (In years last birthday) 84 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12 CITIZEN OF WHAT COUNTRY? United States	
13 FATHER'S NAME James M. Etter		14. MOTHER'S MAIDEN NAME Clara Six	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 220-44-8205	
17 INFORMANT Address Sacred Heart Home, Hyattsville, Maryland			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4:00 Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Certificates		19. WAS A TAPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1967, to May 14, 1967, that (I) (we) last saw the deceased alive on May 12, 1967, and that death occurred at 4:00 M, from causes and on the date stated above.			
22a SIGNATURE AK Bowie M.D.		22b. DATE SIGNED	
22c PHYSICIAN'S NAME (Type) AK BOWIE		22d ADDRESS 301 - Constitution Ave WASH DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-17-67	
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d LOCATION (City or Town) (County) (State) ARLINGTON, VA.	
24. FUNERAL DIRECTOR Francis J. Collins 2821-145 STNW DC		25a. REC'D BY REGISTRAR MAY 17 1967	
		25b. REGISTRAR'S SIGNATURE f Charles Judge	

MEDICAL CERTIFICATION


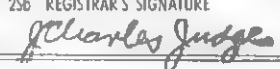


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07183

CERTIFICATE OF DEATH

07167

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Pro Georges				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges General Hospital				d. STREET ADDRESS 5314 Decatur st		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Paul S Steele				4. DATE OF DEATH Month Day Year May 15, 19 67				
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 13, 1904		9. AGE (In years last birthday) yrs 62	10. IF UNDER 1 YEAR Months Days Hours M.n. _____	11. IF UNDER 24 HRS Hours M.n. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus driver			10b. KIND OF BUSINESS OR INDUSTRY Grayhound co		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Steele				14. MOTHER'S MAIDEN NAME Dalton				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 173 07 0719		17. INFORMANT Kathryn Steele		Address Hyattsville, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4 : DUE TO Hypertensive arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO _____ (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH minutes over 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I (a)							19 WAS A TUPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Sept-63 , 19____, to 11 May , 19 67 , that (I) (we) last saw the deceased alive on 11 May 19 67 , and that death occurred at 6:10 AM from causes and on the date stated above.								
22a. SIGNATURE  M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 5-16-67		
22c. PHYSICIAN'S NAME (Type) John Kehoe, M.D.				22d. ADDRESS Riverdale, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 18, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.		
24. FUNERAL DIRECTOR F Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR MAY 18 1967		25b. REGISTRAR'S SIGNATURE 		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-attach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07190

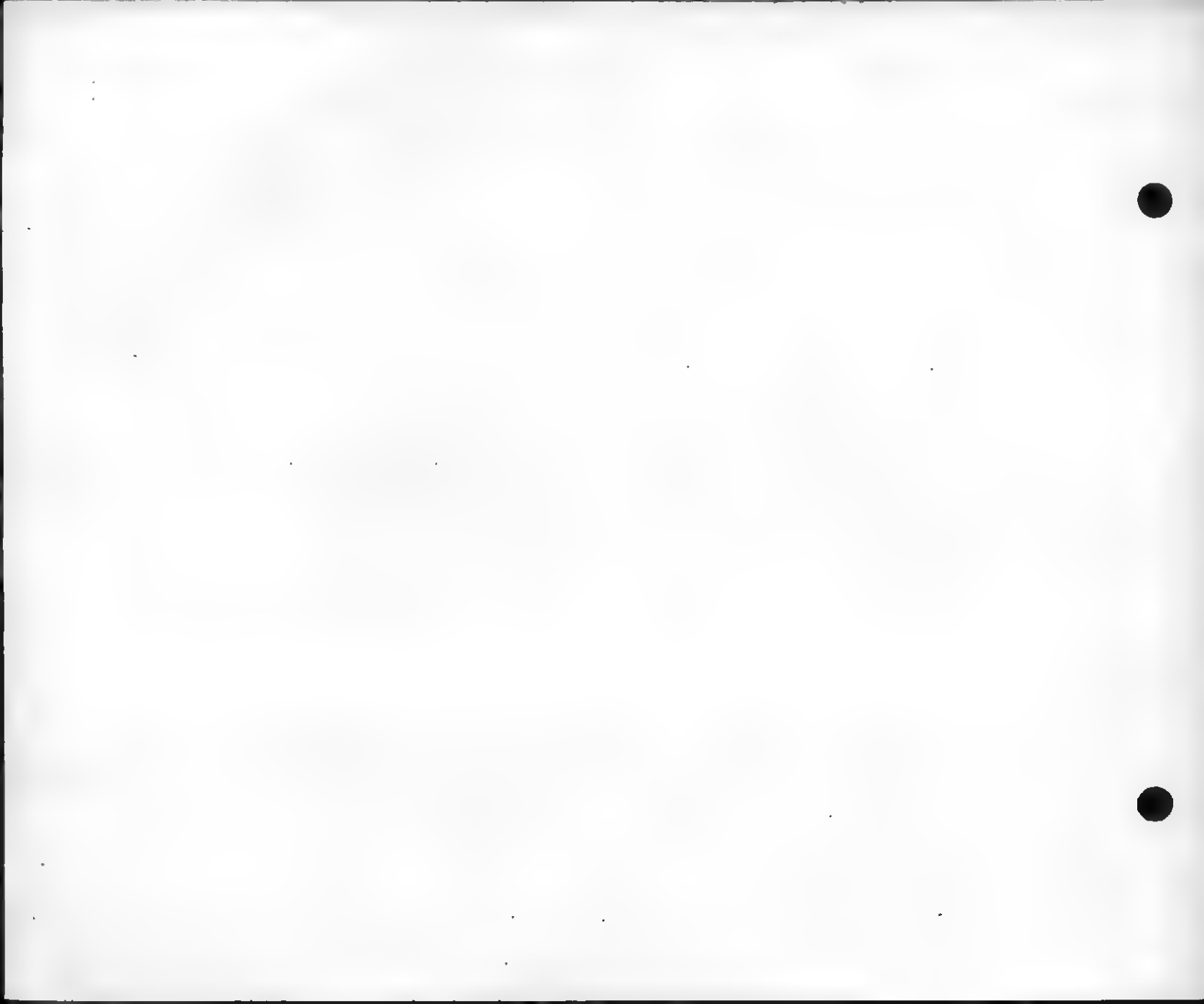
CERTIFICATE OF DEATH

07168

1. PLACE OF DEATH a. COUNTY Prince Georges				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 2820 Crest Avenue			
3. NAME OF DECEASED (Type or print) First Middle Last Elsie Ann Stewart				4. DATE OF DEATH Month Day Year May 16, 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/22/13	9. AGE (n years last birthday) 54 yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Stanley J. Gross				14. MOTHER'S MAIDEN NAME Ross G. Sinek			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 201 05 6556		17. INFORMANT Address Ralph W. Stewart Jr. Same as #2 (son)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interlobar Carcinoma 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of breast DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6 months 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 1967 to May 16, 1967 , that (I) (we) last saw the deceased alive on May 16, 1967 , and that death occurred at 2:15 PM , from causes and on the date stated above.							
22a. SIGNATURE Donald C. Edgren				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DONALD C. EDGREN				22d. ADDRESS Prince Georges Plaza, Hyattsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/19/67		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE MAY 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8 Film 133 9 5 12/67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07191

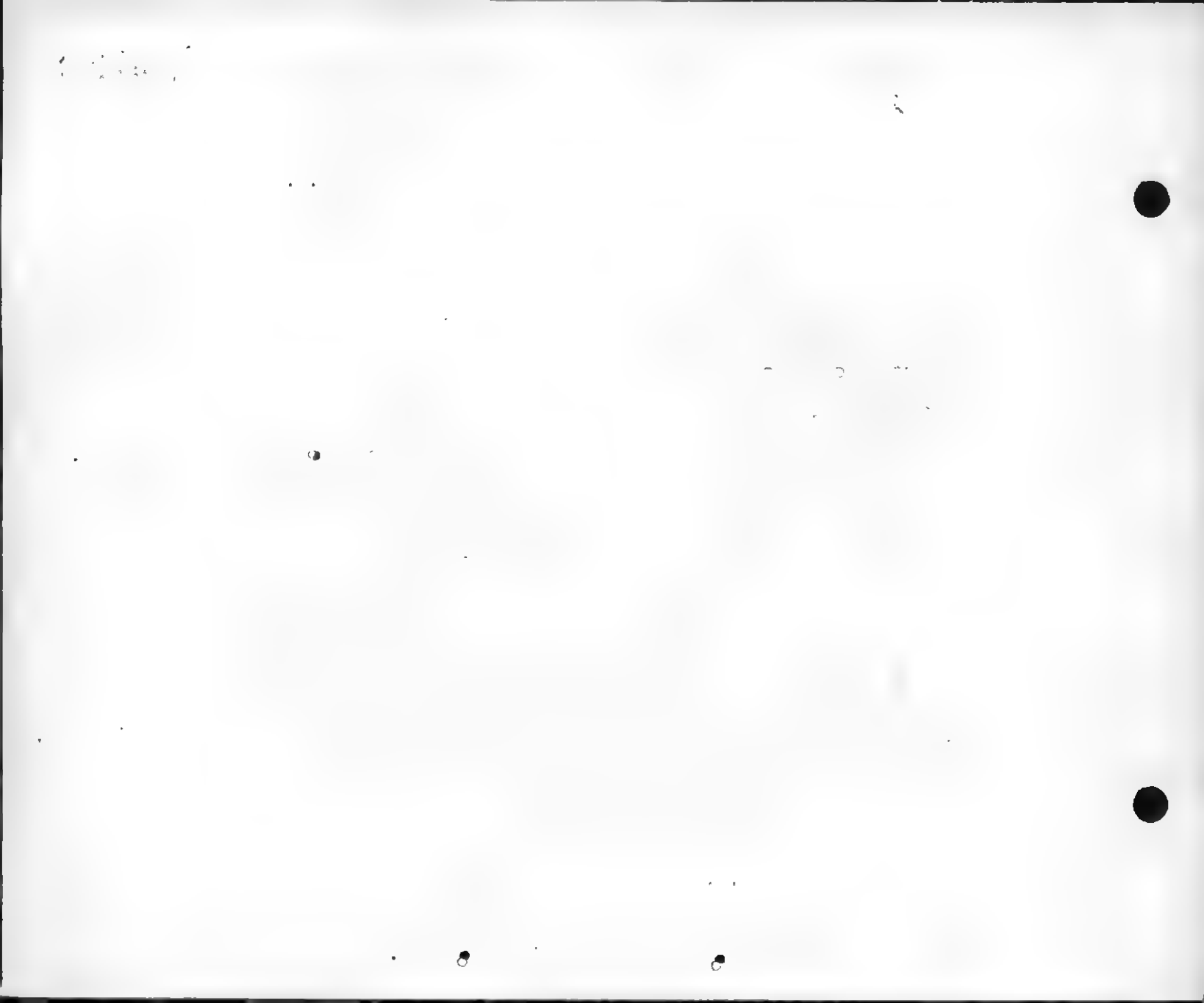
07169

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 15 DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington D.C. c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) 1838 Maryland Avenue d. STREET ADDRESS 1838 Maryland Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) First Middle Last Margaret Melvin Stigger			4 DATE OF DEATH Month Day Year 5 27 19 67		
5 SEX female	6 COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5-10-14/ 15	9 AGE (In years last birthday) 52 yrs	10. FUND 1 YEAR Months Days Hours Min 27 19 67
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) General Housework		10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country) Pa.		12 CITIZEN OF WHAT COUNTRY? USA
13 FATHER'S NAME Robert Daniel			14. MOTHER'S MAIDEN NAME Lena Rawlings		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	17 INFORMANT Address Lena Wallace-mother-5716 8th St., N.W.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage and shock 8254 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Laceration of brain, and DUE TO (c) Multiple fractures of legs and pelvis					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Passenger in car involved in collision			
20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. 8:15am 5-27 19 67		20d. INJURY OCCURRED Where at work <input type="checkbox"/> Not at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home farm factory street, office bldg, etc.) Woodrow Wilson Bridge, Prince George's, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe M.D., Riverdale, Maryland		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 5-28-67	
EXAMINER'S NAME (Type)		ASSISTANT MED. CA. EXAMINER <input type="checkbox"/>		DEPUTY MED. CAL EXAMINER <input checked="" type="checkbox"/>	
23a. PLACE OF CREMATION (If removal specify)		23b. DATE THEREOF 6/1/67		23c. NAME OF CEMETERY OR CREMATORY Carver Memorial Park Maryland	
23d. LOCATION (City or Town) (County) (State) Burial		23e. REC'D BY REGISTRAR Stewart Funeral Home-4001 Penning Road, N.E.		23f. REGISTRAR'S SIGNATURE JUN 1 1967	



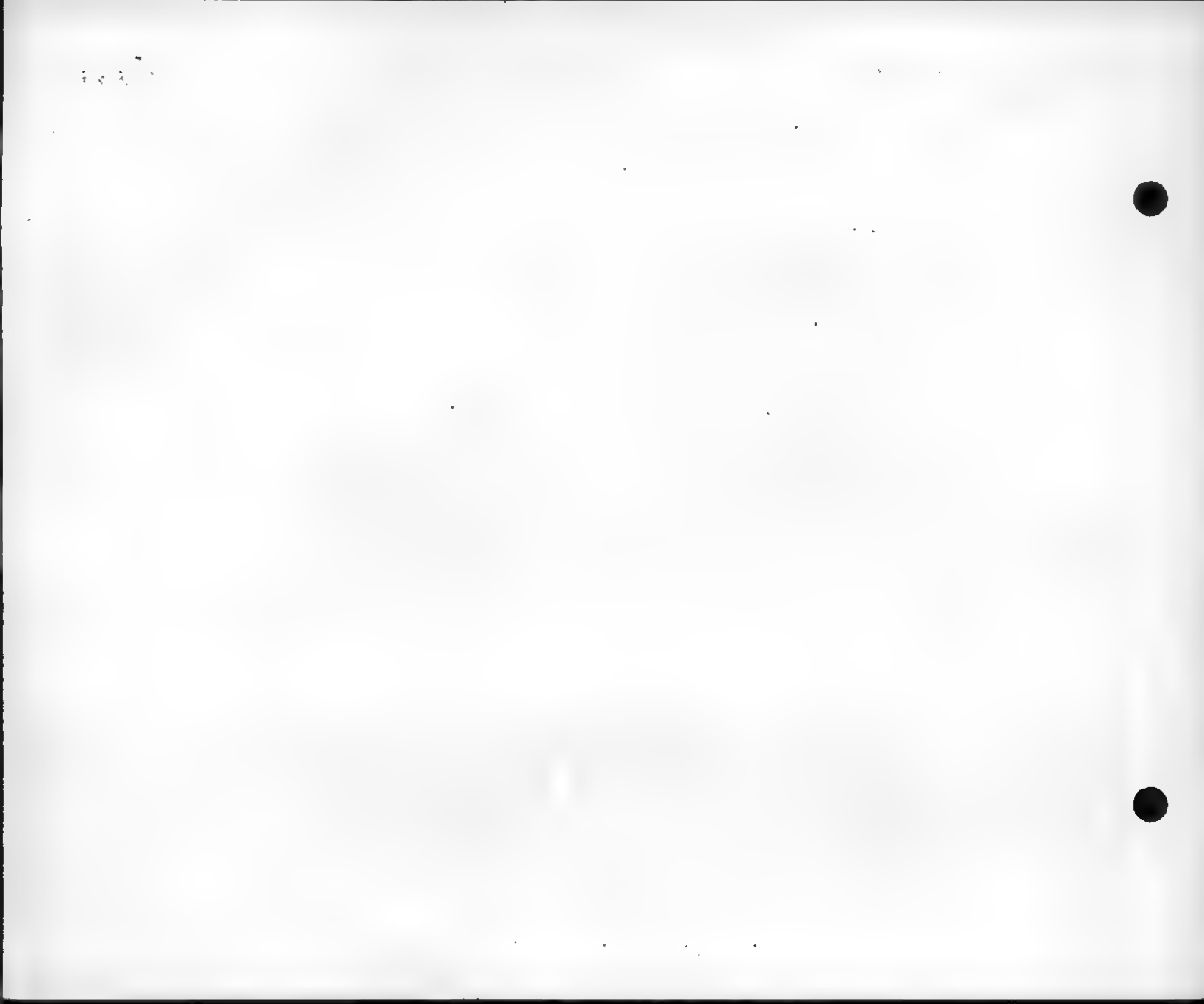
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and to any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07192		07170	
1. PLACE OF DEATH a. COUNTY PRINCE GEORGE COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if inst. before admission) o. STATE MARYLAND b. COUNTY PRINCE GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5 YR.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ANDREWS AIR FORCE BASE HOSP		d. STREET ADDRESS 1501-49TH AVE. S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type of print) First Middle Last DUSTY LANE STOCKING		4. DATE OF DEATH Month Day Year MAY 21 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 JAN 1962 9. AGE (In years lost birthday) 5 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) PRINCE GEORGE CO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME DAVID EDWARD STOCKING		14. MOTHER'S MAIDEN NAME VIRGINIA EVELYN TERO	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT DAVID EDWARD STOCKING - WASHINGTON, D.C.		Address 1501-49TH AVE. S.E.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS WITH MASTOIDITIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACUTE LYMPHOBLASTIC LEUKEMIA (c)			INTERVAL BETWEEN ONSET AND DEATH 33 MONTHS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from JULY, 1966, to MAY, 1967, that (1) (we) last saw the deceased alive on 21 MAY 1967, and that death occurred at 5:48 PM, from causes and on the date stated above.			
22a. SIGNATURE Paul H. Perlstein		22b. DATE SIGNED 21 MAY 1967	
22c. PHYSICIAN'S NAME (Type) PAUL H. PERLSTEIN		22d. ADDRESS CAPT USAF MS USAF HOSP ANDREWS AIR FORCE BASE	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5/25/67	23c. NAME OF CEMETERY OR CREMATORY SPRINGFIELD CENTER	23d. LOCATION (City or town) (County) (State) SPRINGFIELD CENTER, NEW YORK
24. FUNERAL DIRECTOR ROBERT E. WILHELM 4308 SUTLAND ROAD, SUTLAND, MARYLAND		25a. REC'D BY REGISTRAR MAY 24 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
07193 08053											
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brandywine c. LENGTH OF STAY IN 1b 1-Hour d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Brandywine-Waldorf Medical Center						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Naylor d. STREET ADDRESS -- e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Herbert Roy Trueman			4. DATE OF DEATH May 22, 1967			5. SEX Male			6. COLOR OR RACE White		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH March 28, 1891			9. AGE (In years last birthday) 76 yrs.			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Refrigeration Engineer Ice Company		
11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Joshua C. Trueman			14. MOTHER'S MAIDEN NAME Mary Dixon		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.			17. INFORMANT Flora D. Trueman-Naylor, Maryland			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 4201 DUE TO (b) myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 5-10 , 19 67 to 5-22 , 19 67 , that (II) (we) last saw the deceased alive on 5-22 19 67 , and that death occurred at 5:30 PM, from the causes and on the date stated above.											
22a. SIGNATURE Richard Dobson, M.D.						22b. DATE SIGNED 5/22/67					
22c. PHYSICIAN'S NAME (Type) Richard Dobson, M.D.						22d. ADDRESS Brandywine, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE THEREOF 5/24/67			23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory			23d. LOCATION (City, town or county) (State) Suitland Maryland		
24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.						25a. REC'D BY REGISTRAR JUN 9 1967			25b. REGISTRAR'S SIGNATURE Charles Judge		

FOR STATE
HEALTH DEPT.

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6M 1 67

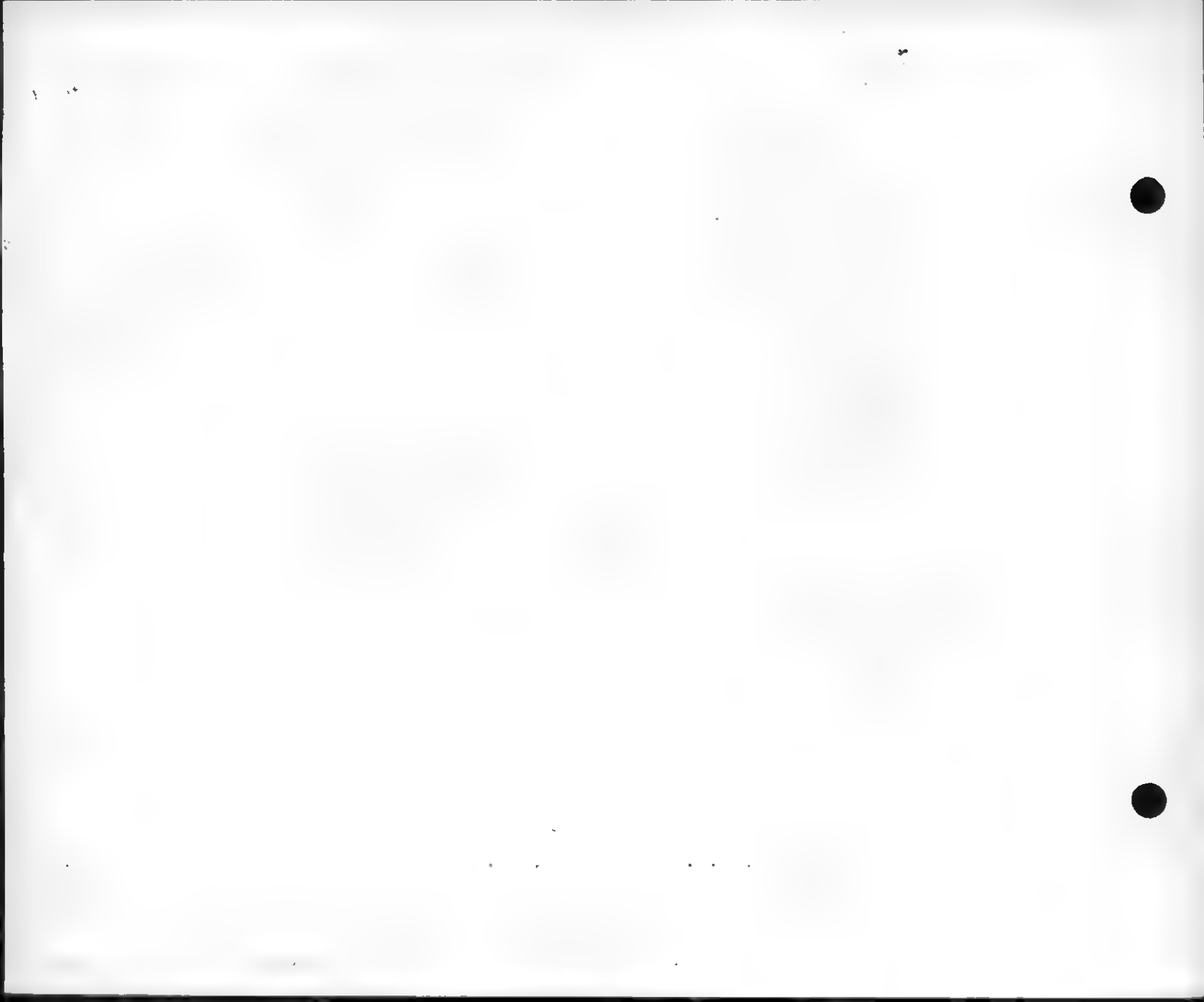
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07194

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07171

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN TB DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		d. STREET ADDRESS 4305 Tonquil Place	
3 NAME OF DECEASED (Type or print) First Cleve Middle A Last Tucker		4 DATE OF DEATH Month 5 Day 1 Year 1967	
5 SEX male	6 COLOR OR RACE white	7 MARRIED WIDOWED X NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12 April 1893
9 AGE (In years lost birthday) 74 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret Pullman Co	
10b K.N. OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY?		13 FATHER'S NAME Yates Tucker	
14 MOTHER'S MAIDEN NAME Martha M. Davis		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16 SOCIAL SECURITY NO 709-12-4961		17 INFORMANT Hazel S. Mazzyck	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH minutes unknown	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 5-1-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	5.4.67	Fort Lincoln Cem	Colmar Manor. Md
24 FUNERAL DIRECTOR Lee Funeral Home 300.4th st N E Wash D.C.		25a REC'D BY REGISTRAR MAY 4 1967	
		25b REGISTRAR'S SIGNATURE J. Charles Judge	



CERTIFICATE OF DEATH

Reg. Dist. No. 07173

97195

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Marlow Heights)</u>		c. LENGTH OF STAY IN TB	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland, (Marlow Heights)</u>		d. STREET ADDRESS <u>4314 Townsley</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Cornell Campbell WAGNER</u>		4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1967</u> <u>December 9</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 9, 1912</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>High School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Education - Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Charlotte, North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. of Am.</u>	
13. FATHER'S NAME <u>Clyde Wagner</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Louise Campbell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>924-03-2030</u>	
17. INFORMANT Address <u>Mrs. Pearl Wagner, 4314 Townsley, Marlow Heights 20031</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart Failure from Probable Coronary Occlusion</u> DUE TO <u>Arteriosclerotic + Hypertensive Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO <u>Arteriosclerosis Generalized</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 minute</u> <u>10 years</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Talked to Med. Examiner before signing this.</u>	
20c. TIME OF INJURY Hour <u>—</u> a. m. <u>—</u> p. m. <u>—</u> 19 <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u> <u>—</u> <u>—</u>	
21. I certify that I attended the deceased from <u>December 20, 1961</u> to <u>May 7, 1967</u> , that I last saw the deceased alive on <u>April 25, 1967</u> , and that death occurred at <u>8:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walcutt W. Gibson</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>4300 St. Barnabaz Road. Marlow Heights, Maryland 20031</u>	
PHYSICIAN'S NAME (Type) <u>Walcutt W. Gibson, M.D.</u>			
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-11-1967</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. W. Address</u> <u>4308 Suitland Road Suitland Maryland</u>		24a. REC'D BY REGISTRAR <u>MAY 11 1967</u>	24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

May 10 1954

Mr. J. Edgar Hoover
U.S. Department of Justice
Washington, D.C.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. Fill in pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07196

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07174

1 PLACE OF DEATH a COUNTY <u>Prince George's</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, 1 institution, residence before admission) b STATE <u>Maryland</u> c COUNTY <u>Prince George's</u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Cheverly</u>		c LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hosp.</u>		d STREET ADDRESS <u>5714 2nd. Ave.</u>	
3 NAME OF DECEASED (Type or print) <u>Charles Walderzak</u>		4 DATE OF DEATH Month <u>5</u> Day <u>17</u> Year <u>1967</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>16 Dec. 1966</u>
9 AGE (In years last birthday) <u>5</u> yrs		10 IF UNDER 1 YEAR Months <u>5</u> Days <u></u> Hours <u></u> Min <u></u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Robert Waldersak</u>		14 MOTHER'S MAIDEN NAME <u>Sharon Hudson</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOC. SEC. SECURITY NO.	
17 INFORMANT <u>Robert Walderzak</u>		Address <u>Same As # 2</u>	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Meningococcal Meningitis</u> DUE TO (b) <u>Waterhouse Friderichsen Syndrome</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D., Riverdale, Md.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL (Cremation or Removal) (Specify) <u>Burial</u>		23b DATE THEREOF <u>5/19/67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Resurrection Cemetery</u>		23d LOCATION (City or town) (County) (State) <u>Prince Georges, Maryland</u>	
24 FUNERAL DIRECTOR <u>Robert E. Wilhelm Funeral Home</u>		25a REC'D BY REGISTRAR <u>MAY 29 1967</u>	
4308 Suitland Road, Suitland, Maryland		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07197

Item #12 Filed 5/18/67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07175

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived f institution Res dence before admission) a. STATE Maryland b COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c LENGTH OF STAY IN 1b DOA			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George General Hospital				d STREET ADDRESS 5678 23rd. Parkway			
3 NAME OF DECEASED (Type or print) First Middle Last Harry Walsh				4 DATE OF DEATH Month Day Year 5 15 1967			
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8 DATE OF BIRTH 29 Sept. 1889	9 AGE (In years last birthday) 77 Yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret			10b KIND OF BUSINESS OR INDUSTRY Plasterer		11 BIRTHPLACE (State or foreign country) England		12 CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME Matthew Walsh				14 MOTHER'S MAIDEN NAME Alice Goth			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no no			16 SOCIAL SECURITY NO no		17 INFORMANT Mary E. Lyles same as # 2.D		Address
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic carcinoma 154X DUE TO Carcinoma of the rectum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH over 3 mo.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. <input checked="" type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D.			EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.			22. DATE SIGNED 5-15-67	
23a BURIAL OR CREMATION REMOVAL (Specify) Burial		23b DATE THEREOF 5.18.67		23c NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d LOCATION (City or Town) (County) (State) Colmar Manor Md	
24 FUNERAL DIRECTOR Lee Funeral Home 300.4th st N E				25a REC'D BY REGISTRAR MAY 17 1967		25b REGISTRAR'S SIGNATURE Charles Judge	

1000



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

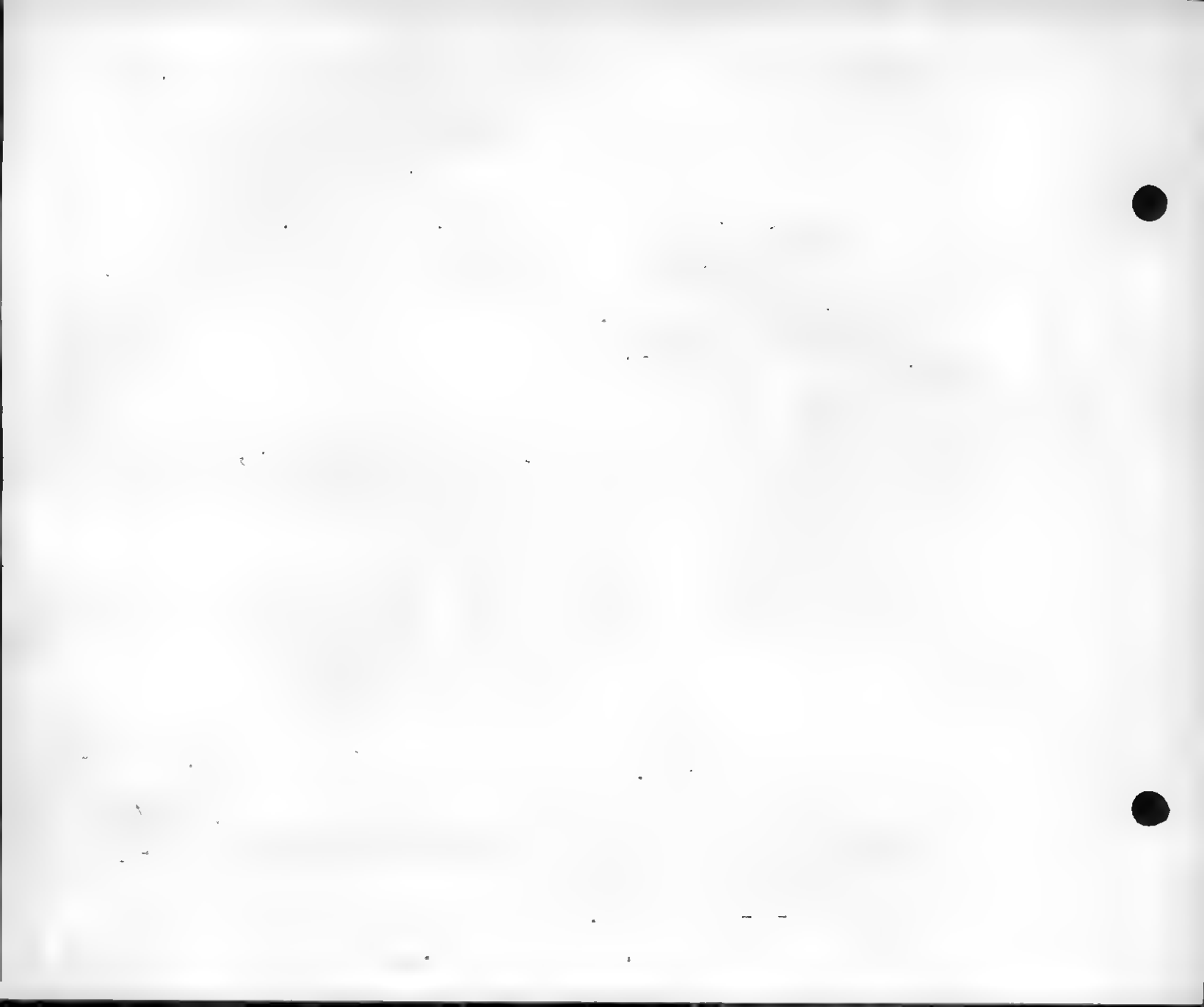
07198

07176

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 14 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital					d. STREET ADDRESS 6905 Central Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Charles			First Middle Last Welch		4. DATE OF DEATH Month Day Year May 25, 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1910		9. AGE (In years last birthday) 57 yrs	10. IF UNDER 1 YEAR Months Days Hours Mm	11. IF UNDER 24 HRS Months Days Hours Mm
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) Taxi-Driver		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (County & State, or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES WELCH				14. MOTHER'S MAIDEN NAME LAURA WELCH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO		17. INFORMANT Address LOUIS WELCH, North Beach, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 465X Pulmonary Embolus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21. I certify that xx (this hospital) attended the deceased from May 11, 1967 , to May 25, 1967 , that xx (we) last saw the deceased alive on May 25, 1967 , and that death occurred at 9:53 PM , from causes and on the date stated above.							
22a. SIGNATURE [Signature]				22b. DATE SIGNED 5/27/67		22c. PHYSICIAN'S NAME (Type) Reynaldo Lee Llacer	
22d. ADDRESS Prince Georges General Hospital				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-29-67		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN		23d. LOCATION (City or Town) (County) (State) COLMAR MANOR, MARYLAND	
24. FUNERAL DIRECTOR GASCH'S 4739 Baltimore Ave. Hyattsville, Md.				25a. REC'D BY REGISTRAR MAY 31 1967		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

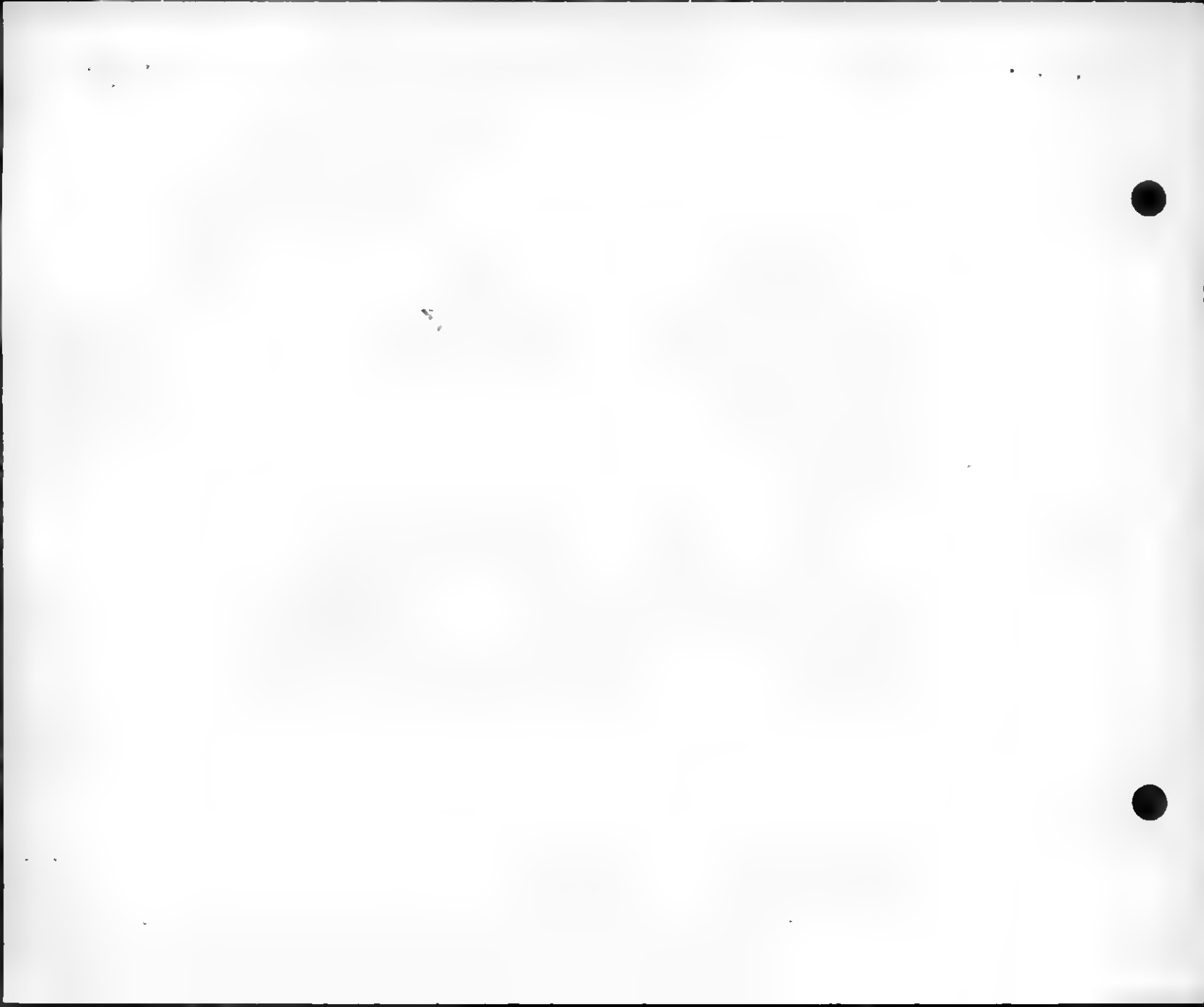
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07199

07177

1 PLACE OF DEATH a COUNTY <u>Prince George's</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived before admission) a STATE <u>District of Columbia</u> b COUNTY <u>Washington</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c LENGTH OF STAY IN MD <u>DOA</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George Gen. Hospital</u>				d STREET ADDRESS <u>409 Trenton St. S.E.</u>			
3. NAME OF DECEASED (Type or print) First <u>Milton</u> Middle <u>H.</u> Last <u>Wells</u>				4 DATE OF DEATH Month <u>5</u> Day <u>17</u> Year <u>1967</u>			
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7-28-1909</u>	9 AGE (In years last birthday) <u>57</u> yrs	10 IF UNDER 1 YEAR Months <u>5</u> Days <u>17</u>		11 UNDER 24 HRS Hours <u>19</u> Min <u>67</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINT - CONTRACTOR</u>				10b KIND OF BUSINESS OR INDUSTRY <u>VIRGINIA</u>		11 BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>				13 FATHER'S NAME <u>Clement W. Wells</u>			
14 MOTHER'S MAIDEN NAME <u>Louise Connelly</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes WWII</u>			
16. SOCIAL SECURITY NO <u>yes WWII</u>				17 INFORMANT <u>Helen E. Wells - SAME AS ITEM #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>minutes over 8 no.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)	
20f (City or town)				20g (County)		20h (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22. DATE SIGNED <u>5-18-67</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVA. (Specify) <u>Burial</u>				23b DATE THEREOF <u>MAY 20-67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	
23d LOCATION (City or Town) <u>Bladenburg Md</u>				23e (County)		23f (State)	
24 FUNERAL DIRECTOR <u>Seneca Bros. 1661-Good Hope Rd SE, WASH DC</u>				25a REC'D BY REGISTRAR <u>MAY 22 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT

Items 20&21 Film 392

9-6-67 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07200

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07178

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND			2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE District Of Columbia b COUNTY		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY in lb 3 days	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			d STREET ADDRESS 1401 Gerard St., N.W.		e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last Stanley Henry White			4. DATE OF DEATH Month Day Year 5 22 19 67		
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-2-1928	9 AGE (In years last birthday) 38 yrs	IF UNDER 1 YEAR Months Days Hours Mins 19 67
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest DUE TO Fibronous pericarditis with pericardial effusion (b) _____ DUE TO _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Driver of car which overturned			
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 5:40 p.m. May 19 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) Rt 214		20f. (City or town, County) (State) Prince G. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John Kehoe</i>		EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED 5-23-67	
23a. BURIAL CREMATION REMOVAL (Specify) Buried		23b. DATE THEREOF 5-27-67		23c. NAME OF CEMETERY OR CREMATORY Harmon	
24. FUNERAL DIRECTOR W.H. Bacon		ADDRESS 3447-14th St. NW		25a. REC'D BY REGISTRAR MAY 25 1967	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

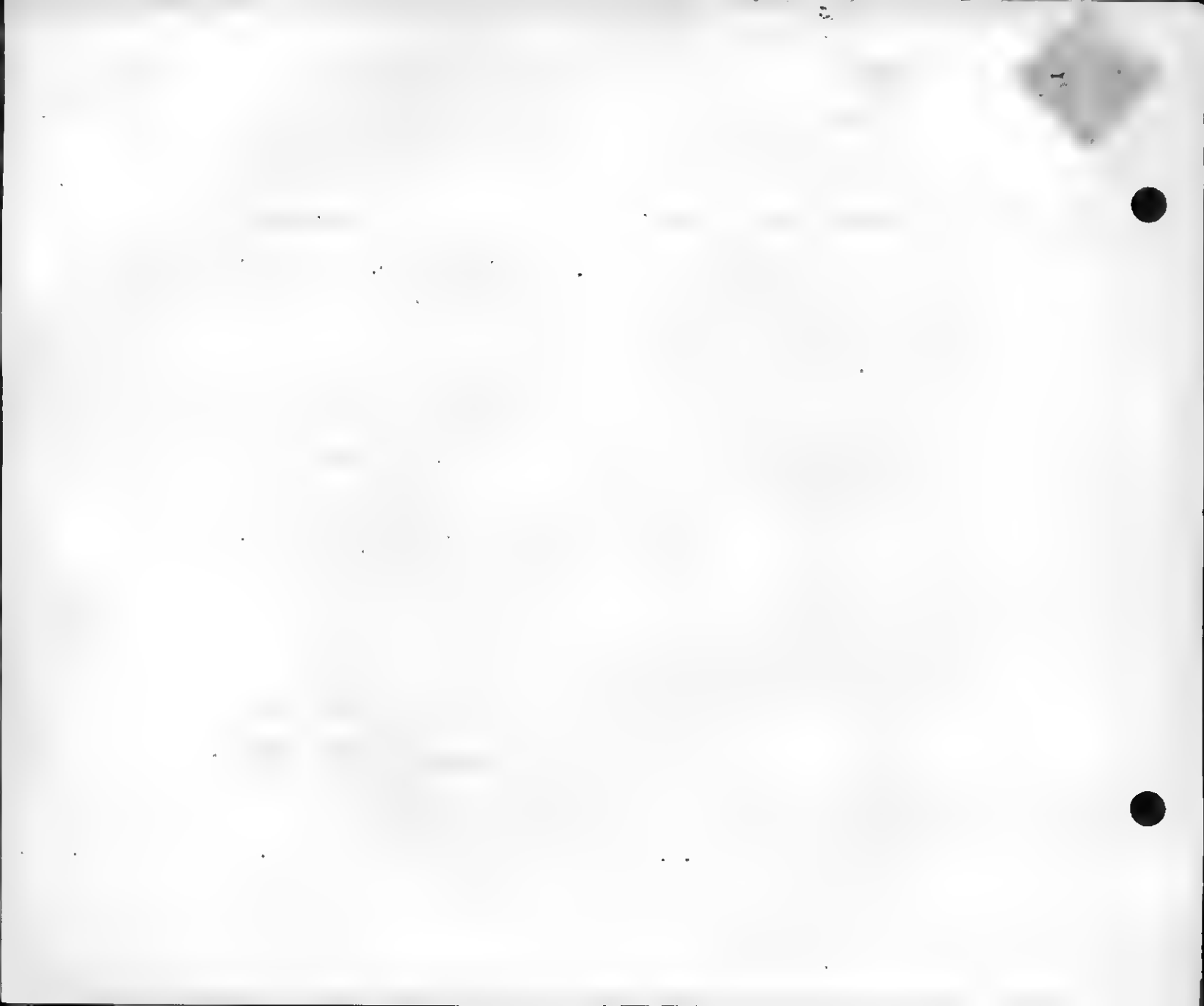
07201

CERTIFICATE OF DEATH

07179

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Prince George's			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c LENGTH OF STAY in 1b 77 days		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d STREET ADDRESS 7421 Simpson Lane		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Ralph Middle I. Last Windsor, Sr.			4. DATE OF DEATH Month May Day 20 , Year 1967				
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/22/03		9 AGE (In years birthday) yrs. 63	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US Gov't.		10b KIND OF BUSINESS OR INDUSTRY Postal Dept.		11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William H. Windsor				14. MOTHER'S MAIDEN NAME Ida Mae King			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO.		17. INFORMANT Address Della C. Windsor-Wife Same as Item #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cervical cancer 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of esophagus						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 4, 19 67 , to May 20, 19 67 , that (I) (we) last saw the deceased alive on May 20, 19 67 , and that death occurred on May 20, 19 67 , at 4:15 AM , from causes and on the date stated above.							
22a. SIGNATURE Bahram Erfan				MD ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 5-20-67	
22c PHYSICIAN'S NAME (Type) Bahram Erfan, M.D.		22d ADDRESS 6813 Riverdale Rd., Riverdale, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 23-1967		23c NAME OF CEMETERY OR CREMATORY Bells Methodist Cemetery		23d LOCATION (City or Town) (County) (State) Camp Springs, Maryland	
24 FUNERAL DIRECTOR Simmons Bros.		ADDRESS Simmons Bros., 1661 Good Hope Rd SE Wash DC		25a REC'D BY REGISTRAR MAY 22 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07202

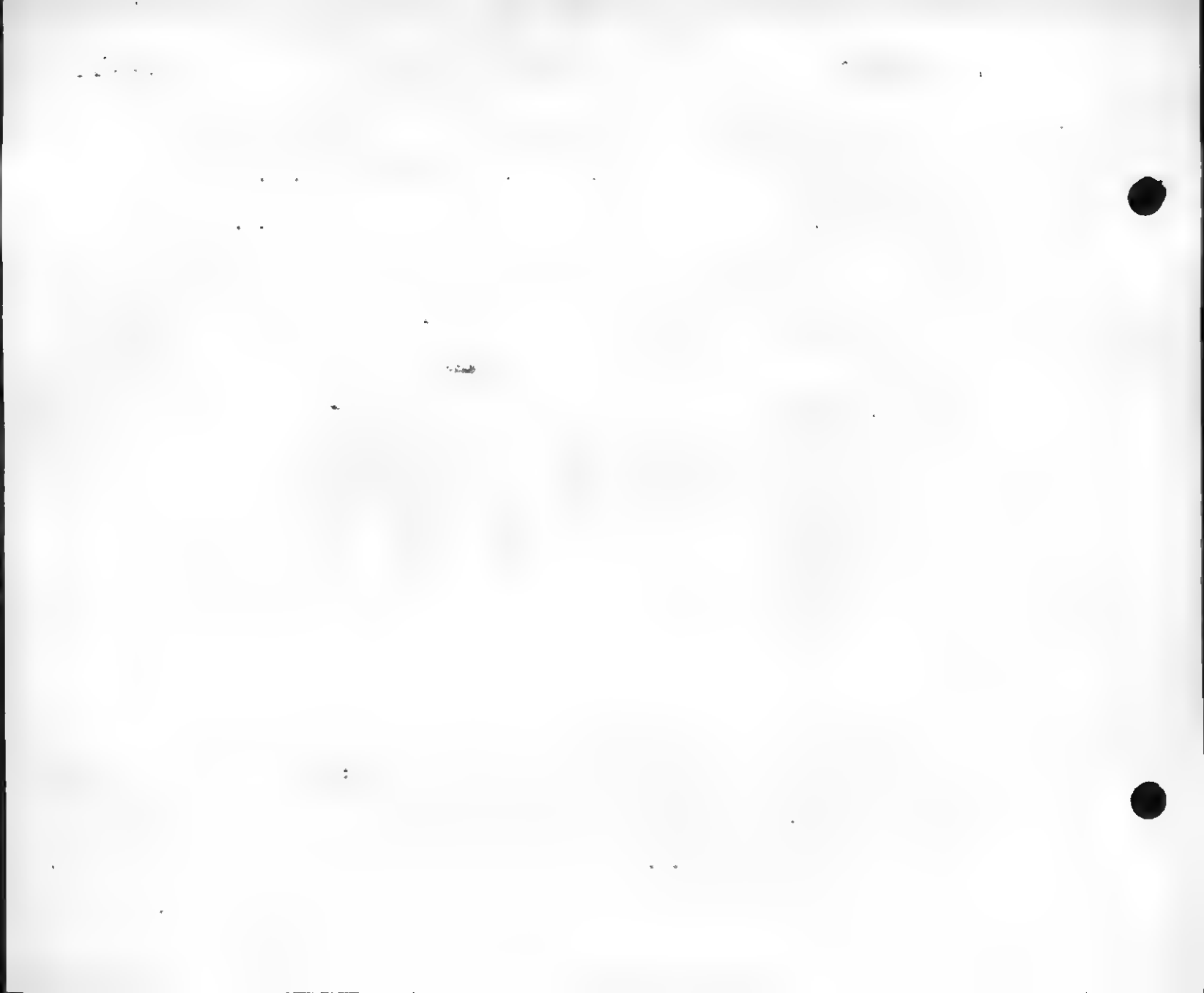
CERTIFICATE OF DEATH

07180

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Washington, D. C. b. COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c LENGTH OF STAY IN 1b XXXX 7 mo.			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital				d STREET ADDRESS 1419 Chapin St., N.W.			
3 NAME OF DECEASED (Type or print) First Middle Last Cora A. Woodbridge				4 DATE OF DEATH Month Day Year May 9, 19 67			
5 SEX F	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12/19/1880		9 AGE (In years last birthday) 86 yrs	10 UNDER 1 YEAR Months Days Hours Min	
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) teacher				10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (County & State, or foreign country) Mass.	
13. FATHER'S NAME James H. Adams				14 MOTHER'S MAIDEN NAME Neill E. F. Adams			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 577-03-9724		17. INFORMANT decendent	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon with extensive metastases DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH 6 mos.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month Day, Year Hour a.m. p.m. 19				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	
20f (City or town) (County) (State)				21. I certify that (X) (this hospital) attended the deceased from 9/23/19 66 to 5/9/1967 , that (X) (we) last saw the deceased alive on 5/9/19 67 , and that death occurred at 10:15 AM from causes and on the date stated above.			
22a. SIGNATURE <i>Moe Weiss</i>				MD ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 5/9/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.				22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.			
23a B. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF May 12, 1967		23c NAME OF CEMETERY OR CREMATORY Wash. National		23d LOCATION (City or Town) (County) (State) Suitland, Md	
24. FUNERAL DIRECTOR W.W. Chambers Co. Inc				ADDRESS 1400 Chapin St. N.W. Wash. D.C.		25a REC'D BY REGISTRAR MAY 15 1967	
				25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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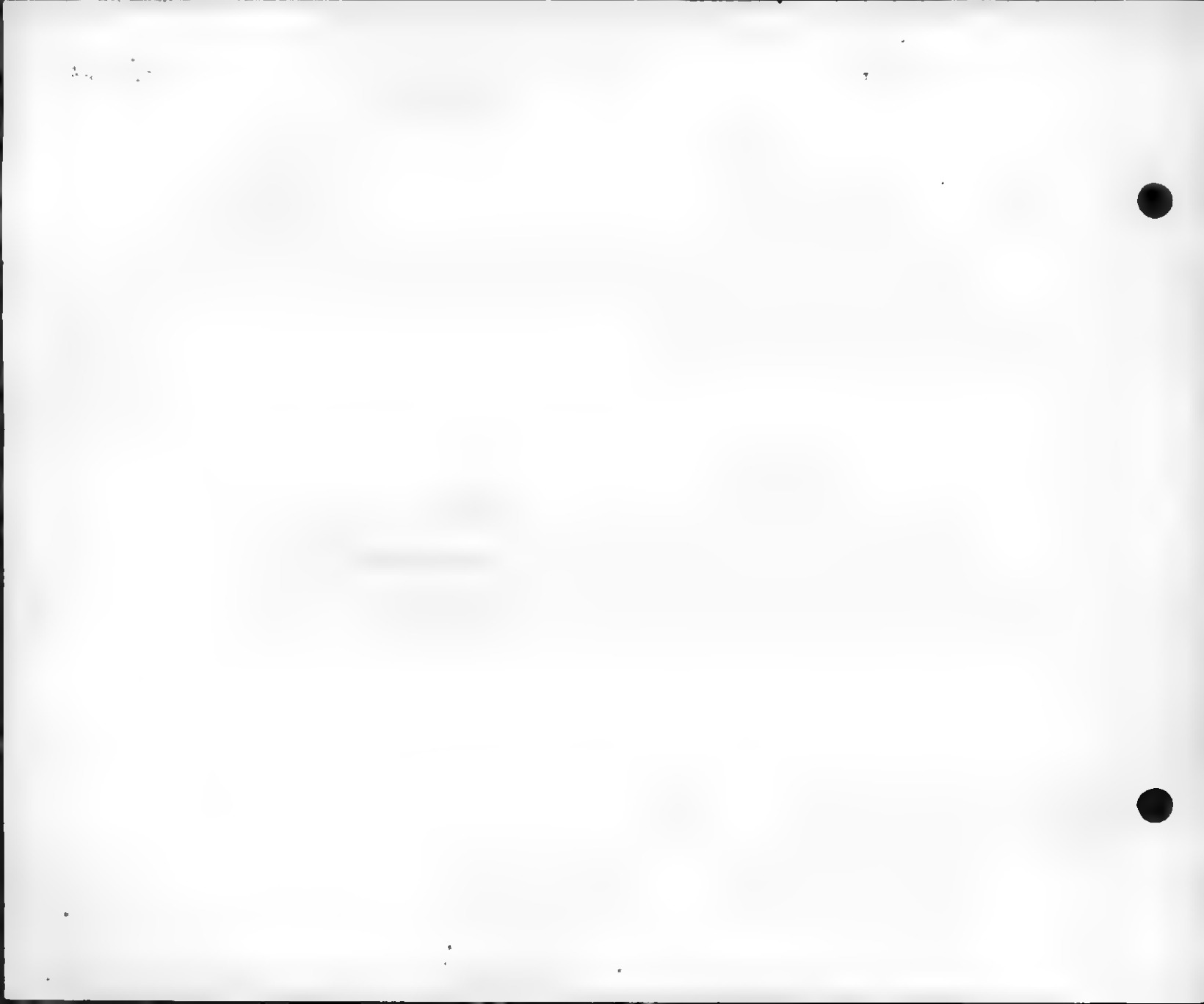


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
37203				CERTIFICATE OF DEATH			07181			
1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince Georges</u> ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			c. LENGTH OF STAY IN 1b <u>3 YRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL MANOR</u>					d. STREET ADDRESS <u>4210 BROCKFIELD DR.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>KATHERINE</u> First Middle Last					4. DATE OF DEATH <u>5</u> Month <u>12</u> Day <u>1967</u> Year					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/12/81</u>		9. AGE (In years last birthday) <u>86</u> yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <u>BAVARIA, GERMANY</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>ALOYSIUS DIENINGER</u>					14. MOTHER'S MAIDEN NAME <u>ANTOINETTE PFALMAN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO <u>577-14-5694</u>		17. INFORMANT <u>SISTER ELIZABETH</u> Address <u>CARROLL MANOR</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>CEREBRAL EMBOLUS</u> 443A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE HEART DISEASE</u> DUE TO (c) <u>HYPERTENSION</u>								INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> <u>2 years</u> <u>2 years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS A TOLPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1-21</u> , 19 <u>65</u> to <u>5-12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>MAY 12 1967</u> , and that death occurred at <u>4:45</u> M, from causes and on the date stated above.										
22a. SIGNATURE <u>Thomas F Collins</u>					M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>THOMAS F. COLLINS</u>					22d. ADDRESS <u>322 - H ST NE.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>5/15/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Park Lawn Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Rockville Md.</u>			
24. FUNERAL DIRECTOR <u>Nalleys Funeral Home</u>					3200 Rhode IIs. Ave. Mt. Rainier		25a. REC'D BY REGISTRAR <u>MAY 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



07182

27204

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Trans-Burial	May 18, 1967	Rest Haven Cemetery	Washington, Georgia		
24. FUNERAL DIRECTOR	ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
Green Carter Monument Warner E. Purphrey, Inc.	8434 Georgia Avenue Silver Spring, Md.		DA MAY 17 1967	Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07183

FOR STATE HEALTH DEPT.

07205

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seabrook		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 6702 96th Place		16-1	
3. NAME OF DECEASED (Type or print) Casper Francis Zimmer				4. DATE OF DEATH Month 5 Day 28 Year 19 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-30-88	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Pittsburgh, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank J. Zimmer				14. MOTHER'S MAIDEN NAME Grace Kouhn			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 579-10-5345		17. INFORMANT Mrs. Catherine O. Zimmer (above address)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 4200				INTERVAL BETWEEN ONSET AND DEATH Minutes over 1 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		22. DATE SIGNED 5-28-67		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/1/67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION (City or Town) (County) (State) Suitland, Md.	
24. FUNERAL DIRECTOR Home Inc.		ADDRESS Mt. Rainier, Maryland		25a. REC'D BY REGISTRAR DATE JUN 5 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

2057

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07206

CERTIFICATE OF DEATH

07184

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 58 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 501 - 68th St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Michael - Zimmerman, Jr.				4. DATE OF DEATH Month Day Year May 24, 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/31/95	9. AGE (In years lost birthday) yrs. 71	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT		10b. KIND OF BUSINESS OR INDUSTRY CIVIL SERVICE		11. BIRTHPLACE (County & State, or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U S	
13. FATHER'S NAME MICHAEL ZIMMERMAN				14. MOTHER'S MAIDEN NAME ANNA RUSHKUS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) W.B.S. W.W.I		16. SOCIAL SECURITY NO. 294-03 4938		17. INFORMANT Address MARY JO HANNA ZIMMERMAN SAME AS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cardiac insufficiency 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma left lung DUE TO (c) 6 months						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) physician attended the deceased from - , 19 60 , to May 24, 1967 , that (I) last saw the deceased alive on May 24, 1967 , and that death occurred at 8:15A M, from causes and on the date stated above.							
22a. SIGNATURE Peter Duus				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 24, 1967	
22c. PHYSICIAN'S NAME (Type) Peter Duus, M. D.				22d. ADDRESS 6124 Central Ave. Capitol Hghts. Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-27-1967		23c. NAME OF CEMETERY OR CREMATORY Mt. OLIVET CEMETERY		23d. LOCATION (City or Town) (County) (State) WASHINGTON, D. C.	
24. FUNERAL DIRECTOR W.W. CHAMBERS CO. RIVERDALE, Md.				25a. REC'D BY REGISTRAR MAY 26 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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